COUNTY COUNCIL OF THE WEST RIDING OF YORKSHIRE

Sixty-eighth

ANNUAL REPORT

OF THE

COUNTY MEDICAL OFFICER

AND

Forty-ninth

ANNUAL REPORT

OF THE

PRINCIPAL SCHOOL MEDICAL OFFICER

YEAR 1956

WEST RIDING HEALTH COMMITTEE

(as at 31.12.56)

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VICE-CHAIRMAN

County Alderman J. W. Trickett

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Hyman, W. M. *(Vice-Chairman of the County Council)*
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Smith, Mrs. E. E.
Sutcliffe, H.
Thackray, C., B.A.
Whittock, M.

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Atkinson, J. W., M.M.
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Blackburn, J., O.B.E.
Cheetham, T.
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Cockroft, H.
Crockatt, D. A.
Cutts, W.
Dawson, T. S., B.E.M.
Denton, Mrs. N.
Fortune, Mrs. N.
Guy, H.
Hanson, G. M.
Hardaker, Mrs. L.
Hardy, J.
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Pickersgill, A.
Pike, Miss I. M. P.
Prendergast, J.
Rankin, H.
Rhodes, Miss M. E.
Smith, J.
Stephens, Dr. J. A.
Sutcliffe, H. H.
Tennant, J. S., M.A.
Thompson, M., B.E.M.
Waddilove, G.
Whitehead, H.
Yorke, J.

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(as at 31.12.56)

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VICE-CHAIRMAN

County Alderman W. M. Hyman
(Vice-Chairman of the County Council)

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Creighton, M.
Flavell, A.
Geldard, Col. N., D.S.O., M.C.
Hudson, Major J. H., C.B.E., M.C. *(Chairman of the County Council)*
King, W.
Lane, J. W., B.E.M.
Runton, Mrs. Ryder, C.B.E. *(Chairman of the Finance Committee)*
Smith, Mrs. J.
Taylor, E., M.B.E.
Thackray, C., B.A.

COUNTY COUNCILLORS

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Bennett, H. V.
Boland, C. W.
Broughton, C. T.
Clegg, A. H.
Craven, A.
Crowther, A. C.
Derbyshire, S.
Dews, C.
England, Mrs. E. L., B.E.M.
Fitton, Mrs. C.
Fitzpatrick, Mrs. L. I.
Fortune, Mrs. N.
Green, Mrs. H. E., B.A.
Hardaker, Mrs. L.
Martinson, J.
Morton, F.
Nicholson, G. H.
Oldham, J. F.
Payne, J. E.
Ratcliffe, Mrs. E.
Rhodes, J.
Smith, H.
Stott, S.
Tomlinson, Sir Thomas, B.E.M.
Wright, G., M.B.E.

Added Members:—

Adshead, H. J.
Lawton, J. A., M.A., B.SC., M.ED.
Martin, Mrs. M., LL.B.
Morris, Sir Charles, M.A.
Priestley, R. E.
Rowe, Miss W. E. M.
Semmens, Mrs. H. W.
Warren, R. A. D., B.A.
White, Mrs. D. M., B.A.
Whittaker, Dr. J. M., F.R.S.

STANDING SUB-COMMITTEES OF THE WEST RIDING HEALTH COMMITTEE

Ambulance Sub-Committee.—All matters relating to the County Ambulance Service. (Section 27, National Health Service Act, 1946.)

Public Health Sub-Committee.—Matters relating to the Pharmacy and Poisons Act, 1933; Housing (Rural Workers) Acts, 1926 and 1942; Housing Act, 1936; Rural Water Supplies and Sewerage Acts, 1944-55; Nurses' Acts, 1943-45; Vaccination and Immunisation (Section 26), Venereal Diseases, Public Health Propaganda (Section 28), under the National Health Service Act, 1946; Food and Drugs Act, 1955; Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949-53; Shops Act, 1950; and all other powers and duties of the Health Authority not delegated to another Standing Sub-Committee.

Mental Health Sub-Committee.—All matters relating to the duties of the Local Health Authority under the Lunacy and Mental Treatment Acts and the Mental Deficiency Acts, and the care and after-care of persons suffering from mental illness or mental defectiveness. (Sections 28 and 51, National Health Service Act, 1946.)

Welfare Sub-Committee.—Arrangements for the prevention of illness, the care of persons suffering from illness other than mental illness, or the after-care of such persons. (Section 28, National Health Service Act, 1946, and the Public Health (Tuberculosis) Regulations, 1952.)

Arrangements for promoting the welfare of persons who are blind, deaf or dumb and other persons who are substantially and permanently handicapped by illness, injury, or congenital deformity, or such other disabilities as may be prescribed by the Minister of Health, and arrangements with Voluntary Organisations therefor. (Sections 29 and 30, National Assistance Act, 1948.)

Assistance grants to voluntary organisations providing meals or recreational facilities for old people. (Section 31, National Assistance Act, 1948.)

Arrangements for the protection of property of persons admitted to hospitals, etc. (Section 48, National Assistance Act, 1948.)

The recovery of charges and expenses where permissible in respect of all services provided by the Health Committee.

The West Riding Distress Fund.

Welfare Accommodation Sub-Committee.—The provision and management of residential accommodation for persons who, by reason of age, infirmity or any other circumstances, are in need of care and attention which is not otherwise available to them. (Sections 21-24, National Assistance Act, 1948.)

Arrangements with Voluntary Organisations and other Local Authorities for the provision of accommodation in property maintained by them. (Section 26, National Assistance Act, 1948.)

The registration of disabled persons or aged persons homes. (Sections 37-39, National Assistance Act, 1948.)

Registration of charities for disabled persons. (Section 41, National Assistance Act, 1948.)

Care of Mothers and Young Children and Nursing Services Sub-Committee.—The duties of the County Council in respect of Nursing Homes (Sections 187-194) and Notification of Births (Section 203), under the Public Health Act, 1936; the care of mothers and young children (Section 22), domiciliary midwifery (Section 23), health visiting (Section 24), home nursing (Section 25) and domestic help (Section 29) services under the National Health Service Act, 1946; the Nursery and Child Minders Regulation Act, 1948; and the Midwives Act, 1951.

JOINT STANDING SUB-COMMITTEE OF THE WEST RIDING HEALTH AND EDUCATION COMMITTEES

Divisional, School Health and Dental Services Sub-Committee.—All matters appertaining to the Divisional Health Administration (Section 111, Local Government Act, 1933); and the School Health and County Dental Services. (Education Act, 1944.)

STANDING SUB-COMMITTEE OF THE WEST RIDING EDUCATION COMMITTEE

Special Services Sub-Committee.—All matters appertaining to the ascertainment of handicapped pupils and the provision of special educational treatment. (Education Act, 1944.)

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To the Chairman and Members of the Health Committee.

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present the Annual Report on the public health and preventive medical services in the West Riding Administrative Area for the year 1956.

The Ministry of Health Circular 19/56 of the 11th December, 1956, which requested the preparation of the Annual Report, indicated that it should follow the usual lines but that full information should be given on the developments in the home nursing service and a brief description of developments in the services which assist in the prevention of the break-up of families. The description of the home nursing service and work towards the prevention of the break-up of families will be found in Part IV.

The three changes in the lay-out of the Report made last year have been continued this year, namely the grouping in one Part of the various services under the National Health Service Act, with the sections of the Act appearing as sub-headings; a Part devoted to Divisional Administration, although not so detailed as last year; and the placing of the School Health Report embodying the Principal School Dental Officer's Report, and the Report of the Divisional School Medical Officer for the Excepted District of Keighley at the end for easier reference.

The vital statistics of the County Administrative Area are again satisfactory. The live birth rate has increased from 15·3 per 1,000 estimated population to 16·4, and the death rate from all causes is 11·8, an increase from 11·7 in 1955. The death rate from tuberculosis of the lungs has remained at the same low figure as last year, namely 0·11 and the death rate from other tuberculous disease shows a slight increase to 0·02. Last year the lowest rates were recorded for infant mortality and neo-natal mortality, but unfortunately these rates have not been maintained; infant mortality having risen from 26·2 to 27·1 per 1,000 live births and neo-natal mortality from 17·4 to 19·7. Comment is made elsewhere in the Report on these figures and the problem remains of reducing the number of infant deaths occurring in the first four weeks of life, particularly in the first week. I have to report that the still-birth rate of 23·1 per 1,000 total births is the lowest ever recorded for the Administrative County. In 1936 the rate was 44·5 and although there has been a considerable drop in this figure in these twenty years it is most difficult to make further reductions. This is a general problem and in May the Ministry of Health asked Chairmen of Boards of Governors and of Hospital Management Committees to arrange meetings of professional representatives of the three parts of the National Health Service in order that free discussion could take place on ante-natal care related to toxaemia of pregnancy. Although the main object was reduction in the number of maternal deaths any methods for the improvement of the ante-natal services must have a general over-all value. An account of the results of the meetings held during the year will be found in Part IV of the Report.

As regards infectious diseases it is gratifying to report that for the second successive year there were no confirmed cases of smallpox or diphtheria. Both these diseases are subject to immunisation procedures and endeavours are made to keep up the level of protection by offering vaccination in the case of smallpox and injections in the case of diphtheria in the first year of the child's life. In 1955 a special appeal was made to family doctors to increase the number of babies vaccinated and as reported this had undoubted useful results. The number of vaccinations of children under one year of age increased during 1956 but there is still much apathy to be overcome in parents to this procedure in the absence of an outbreak of smallpox. A similar apathy is apparent in regard to diphtheria immunisation. By the end of the year only 2,623 children under one year of age had been immunised out of a total of 25,600. There is a noticeable improvement in the position, however, when the child becomes of school age and at the end of the year 75·2 per cent. of all children aged 0—14 years had been immunised at some time in their lives. It cannot be stressed too strongly that the freedom of the County from diphtheria depends largely on parents taking advantage of the facilities provided for the protection of their children.

Early in the year a protective measure against poliomyelitis was introduced by the Ministry of Health, who later issued a vaccine in limited quantities for use by Local Health Authorities. There were over 200,000 children in the age group to which the vaccine was offered and the parents of approximately 30 per cent. gave written consent to the procedure. By the end of the year 6,797 children had received the vaccine. In December the Ministry indicated that the use of the vaccine would be continued in the following year with increased supplies and that it would be possible to include family doctors in the scheme if so desired. After consultation with the Standing Sub-Committee on Co-operation it was recommended to the Local Medical Committee that general medical practitioners should have the opportunity of participating in the scheme.

Whooping cough is another infectious disease for which there is a method of immunisation, and during the year over 11,000 children under 4 years of age received treatment under the Authority's scheme. Many medical practitioners have requested the Authority to make available a combined diphtheria/whooping cough vaccine which would reduce the number of injections to be given to a child in the first year of life, but pending a statement on policy from the Ministry of Health the single diphtheria prophylactic issued by the Ministry, and the single whooping cough vaccine provided by the Authority, have been in use. This matter has been discussed by the Standing Sub-Committee on Co-operation at the request of the Local Medical Committee, and it was agreed to await a Ministry of Health statement before further consideration was given to any alteration in the Authority's scheme.

The offer of vaccination against tuberculosis with B.C.G. to school children aged 13 years and under 14 years was continued and the scheme is now in its third year. Sixty-two per cent. of eligible children accepted the offer during 1956 with the result that over 6,000 were treated following the preliminary tests.

Although the attack rates of many infectious diseases are now reduced to very much less than they were a few years ago, this is not the case with dysentery, which in 1956 produced the highest recorded total of notifications, as there were 2,685 confirmed cases. A full account of the incidence of this disease in the County and measures taken to combat its spread will be found in Part II of the Report.

As mentioned last year there has been a severe restriction on capital expenditure by local authorities in building new clinic premises by the issue of Ministry of Health Circular 3/56, which did not classify such premises among the most urgent needs. The restriction continued throughout the year but a little progress was made by the Authority indicating to the Ministry which projects were of the highest priority when the capital building programme was resumed. The new clinic at Hemsworth was completed and in use during 1956, and the second mobile clinic to serve outlying parts of the South of the County was delivered and put into service.

The restriction on capital expenditure did not apply to the same extent to Occupation Centres for the Mentally Handicapped. During the year the Authority decided the order of priority for five new Centres under consideration and for which plans were prepared, and it was anticipated that the Ministry would give early approval to work commencing on at least two of them. The adaptations of other premises for use as Occupation Centres continued during 1956 with the result that four additional centres will be provided in 1957. This increased accommodation for mental defectives able to benefit from training while living at home will be of great help to the Authority, and we are also grateful to the Regional Hospital Boards for the additional accommodation made by them for defectives requiring institutional treatment. The waiting list for admission to colonies was 138 at the end of the year compared with 179 in 1955 and 247 in 1954.

The Domiciliary Health Services for the Aged were very fully reviewed during the year in a special report to the Policy Sub-Committee of the Health Committee. This report will be found in Part VI. The Home Help Service continues to be mainly employed in aiding the aged and chronic sick, thus enabling many old people to remain in their homes or at least reducing the urgency, in association with the Home Nursing Service, for their admission to hospital. In October, the number of whole-time Home Helps, or the equivalent in part-time workers, was raised from 700 to 800, and during the year the service provided for the aged and chronic sick represented 83·7 per cent. of the total hours available.

The Standing Sub-Committee on Co-operation between the Executive Council and the Local Health Authority has continued to provide a useful means of discussing matters concerning the domiciliary services under the National Health Service Acts provided by General Practitioners and officers of the Local Health Authority. The meetings are not frequent but are held as required.

Part III of the Report dealing with Divisional Administration is much smaller this year as it mainly sets out for reference particulars of the composition of the divisions, the name of the Divisional Medical Officer and the address and telephone number of the Divisional Health Office. Two further amalgamations of divisions were under consideration at the end of the year, and at the time of writing it is known that these will be effected during 1957.

Two Orders were made under the Food and Drugs Act, 1955, during the year declaring further parts of the County to be specified areas. These Orders restrict the retail sale of milk for human consumption to that which is pasteurised, sterilised or tuberculin tested. With these new areas there were, at the end of the year, 43 County Districts involved in this important measure to curtail the risk of infection with bovine tuberculosis, and notice has been received of further Orders to be made in 1957. The County Public Health Inspectors received, as always, willing assistance and co-operation from the local Public Health Inspectors during their preliminary investigations, and later in the supervision necessary after the Orders have come into operation.

Finally I acknowledge once again my debt to officers of other departments for their unfailing friendly help and co-operation, and to all members of the staff of the County Public Health Department for their ever loyal and faithful assistance.

I am,

Yours faithfully,

J. WOOD-WILSON

County Medical Officer.

PART I

VITAL STATISTICS

Area and Population

	Municipal Boroughs and Urban Districts	Rural Districts	Administrative County
Area (acres)	380.328	1,229,431	1,609,759
Population:			
Census, 1931	1,128.519	375.538	1,504,057
Census, 1951	1,161.588	427.530	1,589,118
Estimated (mid-1956)	1.169.600	448.700	1,618,300

Number of Municipal Boroughs, 13; Urban Districts, 55; Rural Districts, 21; Total 89.

Population Trends

The estimated home population of the Administrative County at the 30th June, 1956, was 1,618,300, as compared with 1,610,300 for 1955 and 1,600,000 for 1954. The home population comprises civilians, merchant seamen, and members of the armed forces (including foreign forces) stationed in the Area and forms the basis for the birth and death rates given in this Report.

In my Report for 1954 the broad trend of population change since 1901 was discussed and, whilst it is apparent that to-day more and more people are reaching the older age groups, further consideration is required of the effect of the increased birth rate during the period 1944 to 1948. The table below gives the estimated population of the Administrative County in age groups for the years 1956, 1961, 1966 and 1971. These figures are the findings of a projection based on the 1951 Census, the 1952 East and West Ridings Region Net Reproduction Rates and the West Riding Mortality Rates. It is impossible to forecast migration and no allowance has been made.

According to the 1951 Census 8·8 per cent. of the population were aged under 5 years, approximately 14·2 per cent. of school age, 66·5 per cent. between 15 and 65 and 10·5 per cent. were 65 years or over. From the estimated figures for 1956 the corresponding proportions were 7·4, 15·9, 65·8 and 10·9 per cent.

With regard to sex, it is estimated that for 1956 males comprised 48·5 per cent. of the population and females 51·5. The excess of females in the population is in no way attributable to a higher birth-rate among female children; the contrary is the case. The number of male children born is always higher than the number of females but mortality is higher among males, especially at the younger ages and, at some point before the age of 30, the numerical advantage passes from males to females and is never recovered.

With regard to the future, with the proportion of persons aged 65 and over increasing progressively, apart from an ever increasing financial burden being thrown on the wage earning section of the community, we must re-examine our domiciliary schemes and make suitable provision.

When the over-all picture is considered it appears that we can look forward to a steady increase in total population until roughly 1970 by which time the children resulting from the bulge in the birth rate of 1944 to 1948 will have reached maturity and there may well be a return to the higher birth rates prevailing after the last war.

Age Group Years	1951 Census	Estimated 1956	Estimated 1961	Estimated 1966	Estimated 1971
0 –	139,302	119,750	115,000	113,250	117,200
5 –	119,210	138,650	119,150	114,400	112,675
10 –	106,831	118,950	138,350	118,875	114,150
15 –	98,340	106,600	118,700	138,000	118,600
20 –	102,232	98,000	106,200	118,225	137,450
25 –	230,488	220,850	198,500	202,475	222,550
35 –	239,467	227,150	226,600	217,025	195,100
45 –	220,377	230,700	229,850	217,950	217,575
55 –	166,325	180,900	197,200	206,150	205,300
65 –	115,842	119,100	124,950	136,050	147,850
75 –	45,605	51,750	54,450	56,150	59,250
85 and over	5,099	5,900	7,050	7,950	8,300
All ages	1,589,118	1,618,300	1,636,000	1,646,500	1,656,000

Summary for 1956

The live birth rate was 16·4; the stillbirth rate per 1,000 live and still births 23; the live premature birth rate per 1,000 live births was 69. The death rate from all causes was 11·8; diphtheria nil; whooping cough 0·004; measles 0·001; meningococcal infections (cerebro-spinal fever etc.) 0·006; acute poliomyelitis 0·001; tuberculosis of the lungs (respiratory system) 0·11; other forms of tuberculosis 0·02; respiratory diseases 1·22; cancer 1·89; heart and circulatory diseases 4·47 per 1,000 population. Infant mortality was 27 and maternal mortality 0·52 per 1,000 live and still births.

A comparison of the figures for the past 67 years is given in the following table:—

Year	Live Birth Rate	Death Rate All Causes	Zymotic Death Rate	Tuberculosis of lungs Death Rate	Other Tuberculous Diseases Death Rate	Respiratory Diseases Death Rate	Cancer Death Rate	Stillbirths per 1,000 total births	Maternal Mortality per 1,000 total births	Infant Mortality
1890–1909	28·9	16·7	1·89	1·19	0·52*	3·20	0·77*	†	†	147
1910–1919	22·5	14·5	1·26	0·84	0·41	2·58	0·98	†	†	112
1920–1929	20·2	12·4	0·56	0·68	0·25	2·08	1·20	†	†	82
1930	16·9	11·4	0·33	0·57	0·20	1·35	1·33	45	5·96	65
1931	16·1	12·4	0·38	0·57	0·16	1·64	1·32	45	5·56	74
1932	15·8	12·1	0·39	0·52	0·17	1·33	1·46	48	4·97	70
1933	15·0	12·2	0·30	0·49	0·14	1·36	1·42	47	5·94	70
1934	15·2	11·7	0·41	0·44	0·12	1·16	1·44	48	5·53	58
1935	15·0	11·9	0·28	0·48	0·10	1·13	1·48	47	4·34	58
1936	15·1	12·3	0·29	0·44	0·12	1·25	1·51	45	4·16	63
1937	15·2	12·7	0·21	0·46	0·11	1·23	1·60	45	3·74	60
1938	15·5	11·6	0·23	0·38	0·11	0·99	1·55	44	3·58	51
1939	15·2	12·2	0·18	0·41	0·10	1·01	1·52	42	2·92	54
1940	15·3	13·4	0·18	0·42	0·11	1·94	1·58	40	3·13	56
1941	15·4	12·3	0·22	0·42	0·12	1·43	1·68	39	2·61	57
1942	17·0	11·7	0·18	0·42	0·12	1·26	1·65	36	3·23	49
1943	17·8	12·7	0·19	0·43	0·12	1·63	1·72	34	2·40	50
1944	20·2	12·1	0·12	0·37	0·09	1·32	1·79	31	1·92	44
1945	17·9	12·3	0·19	0·38	0·09	1·36	1·80	30	1·73	51
1946	19·7	11·9	0·13	0·36	0·08	1·31	1·72	29	1·80	44
1947	21·5	12·3	0·16	0·39	0·09	1·37	1·80	26	1·28	45
1948	18·5	11·3	0·12	0·37	0·07	1·29	1·74	24	1·15	39
1949	17·2	12·1	0·08	0·32	0·05	1·44	1·81	24	0·83	38
1950	16·3	11·8	0·10	0·25	0·04	1·18	1·83	24	0·98	35
1951	15·8	12·7	0·10	0·24	0·04	1·48	1·80	26	0·93	32
1952	15·4	11·5	0·07	0·16	0·03	1·11	1·92	25	0·80	30
1953	15·7	11·6	0·08	0·16	0·02	1·20	1·88	25	0·51	29
1954	15·1	11·9	0·08	0·16	0·02	1·16	2·01	26	0·89	28
1955	15·3	11·7	0·07	0·11	0·01	1·17	1·90	26	0·67	26
1956	16·4	11·8	0·07	0·11	0·02	1·22	1·89	23	0·52	27

* This rate is for the 10 years 1900—1909.

† Figures not available.

In the above table, the birth and death rates are per 1,000 estimated population; the stillbirth and the maternal mortality rates are per 1,000 total births (i.e., per 1,000 live plus still births); the infant mortality rates are per 1,000 live births.

The incidence of, and the mortality from smallpox, enteric fever including paratyphoid fever, scarlet fever, diphtheria, measles, whooping cough, and diarrhoea in infants under two years of age was formerly considerably more than those of other infectious diseases. They were thus classified as the seven principal zymotic or infectious diseases, and it was customary to give a combined death rate therefrom denominated the "zymotic diseases death rate", or the "zymotic death rate". The zymotic death rates shown above are on this basis up to and including that for the year 1949. The mortality from all of these seven diseases has declined considerably and in some cases is now below that of some infectious diseases not included in the classification. Therefore, the combined mortality from the zymotic or infectious diseases is now best shown by a combined death rate from infective and parasitic diseases excluding tuberculosis, influenza, acute primary and influenzal pneumonia, enteritis and certain localised infections. The rates from and including 1950 are shown on this new basis.

The respiratory diseases death rate is the combined death rate from bronchitis, pneumonia, and other respiratory diseases excluding tuberculosis and influenza.

Births and Infant Mortality

The number of live births registered during the year and allocated to the Administrative County was 26,468 (13,625 males. 12,843 females). This is an increase of 1,867 (7·6 per cent.) over 1955 and of 1,786 (7·2 per cent.) over the average of the five years 1951–1955. The live birth rate for the year based on the number of live births per 1,000 of the population was 16·4 compared with 15·3 in the previous year and the average rate of 15·5.

Of the live births 975 were illegitimate compared with 905 in 1955 and an average of 932 for the five years 1951–1955. Since 1951 the percentage of births registered as illegitimate has varied only slightly from year to year; the percentage in 1956 was 3·7, the same as the rate for 1955 and the average for the years 1951–1955.

Stillbirths registered during the year numbered 625 and with 26,468 live births registered during the same period these stillbirths are equivalent to a rate of 23·1 per 1,000 total births, the lowest rate ever recorded for the Administrative County. When compared with the rate of twenty years ago remarkable reductions have been effected, but more recently very little progress has been made. The loss of a child's life by stillbirth is just as regrettable as the loss of a liveborn infant, and intensified investigations are required if further reductions in the number of stillbirths occurring are to be achieved.

The steady fall in the infant mortality rate year by year has become a regular comment in my Annual Reports, and it is disappointing having to report that in 1956 there were 73 more deaths of infants under one year of age than in the previous year. The 718 infant deaths resulted in a mortality rate per 1,000 live births of 27·1, which is slightly above the lowest rate ever recorded for the Administrative County of 26·2 in 1955. Not many years ago a rate of this level seemed almost an ideal of achievement, but, even so, it is far too high when compared with the corresponding rate for England and Wales of 23·8, and there is ample room for further improvement.

The trend of the infant mortality rate since the beginning of the century in the Administrative County is shown in the following table:—

Period	Average Infant Mortality Rate	Period	Average Infant Mortality Rate
1900–1909	139	1945–1949	43
1910–1919	112	1950–1954	31
1920–1929	82	1955	26
1930–1939	62	1956	27
1940–1944	51		

The experience of recent years has been that by far the majority of infant deaths take place in the neo-natal period, and whilst remarkable reductions have been made at ages between 4 weeks and 1 year there has been no similar decline in neo-natal mortality. In the short period covered by the following table it will be seen that while infant mortality fell by 22 per cent. neo-natal mortality only declined by 2·5 per cent.

	Number of Deaths							Deaths per 1,000 Live Births						
	1950	1951	1952	1953	1954	1955	1956	1950	1951	1952	1953	1954	1955	1956
Male Infants—														
Under 4 weeks	319	297	285	265	252	253	307	23·8	22·8	22·6	20·3	20·2	20·0	22·5
4 weeks—3 months ..	88	72	46	62	61	50	37	6·6	5·5	3·6	4·8	4·9	3·9	2·7
3—6 months	76	61	47	56	52	42	51	5·7	4·7	3·7	4·3	4·1	3·3	3·8
6—12 months	48	53	38	43	36	24	25	3·6	4·1	3·0	3·3	2·9	1·9	1·8
Total under 1 year ..	531	483	416	426	401	369	420	39·7	37·1	32·9	32·7	32·1	29·1	30·8
Female Infants—														
Under 4 weeks	203	176	205	200	189	175	214	16·2	14·6	17·2	16·7	16·2	14·6	16·7
4 weeks—3 months ..	57	51	45	43	37	36	28	4·6	4·2	3·8	3·6	3·2	3·0	2·2
3—6 months	69	54	36	27	32	38	25	5·5	4·5	3·0	2·2	2·7	3·2	1·9
6—12 months	44	34	34	37	18	27	31	3·5	2·8	2·9	3·1	1·6	2·3	2·4
Total under 1 year ..	373	315	320	307	276	276	298	29·8	26·1	26·9	25·6	23·7	23·1	23·2
All Infants—														
Under 4 weeks	522	473	490	465	441	428	521	20·2	18·8	20·0	18·6	18·3	17·4	19·7
4 weeks—3 months ..	145	123	91	105	98	86	65	5·6	4·9	3·7	4·2	4·0	3·5	2·4
3—6 months	145	115	83	83	84	80	76	5·6	4·6	3·4	3·3	3·5	3·2	2·9
6—12 months	92	87	72	80	54	51	56	3·5	3·5	2·9	3·2	2·2	2·1	2·1
Total under 1 year ..	904	798	736	733	677	645	718	34·9	31·8	30·0	29·3	28·0	26·2	27·1

With the realisation that neo-natal mortality is remaining fairly stationary, research is proceeding both in this country and abroad, seeking the causes of early infant death. Many of the deaths are of children who live no longer than a day or, at most, a week, as will be seen from the following table:—

	Number of Deaths							Deaths per 1,000 Live Births						
	1950	1951	1952	1953	1954	1955	1956	1950	1951	1952	1953	1954	1955	1956
Under 1 day	193	176	229	198	184	185	235	7·5	7·0	9·3	7·9	7·6	7·5	8·9
1—7 days	218	221	183	190	193	180	210	8·4	8·8	7·5	7·6	8·0	7·3	7·9
1—4 weeks..	111	76	78	77	64	63	76	4·3	3·0	3·2	3·1	2·7	2·6	2·9
Total under 4 weeks ..	522	473	490	465	441	428	521	20·2	18·8	20·0	18·6	18·3	17·4	19·7

When deaths from separate causes are considered the number of deaths within the groups of diseases contained in the International Short List is given on page 13, but to obtain a proper appreciation of the cause of death a finer analysis has been made as follows:—

Ætiological Group	Cause of Death (and International Classification number)	Age at Death						
		Under 1 day	1 day and under 1 week	1 week and under 1 month	1 month and under 3 months	3 months and under 6 months	6 months and under 1 year	Total under 1 year
ALL CAUSES	All Causes	235	210	76	65	76	56	718
Prenatal and Natal Group (including congenital malformations)	Congenital malformations (750–759)	22	28	26	20	14	10	120
	Total causes mainly of prenatal and natal origin other than congenital malformations..	204	160	24	4	—	1	393
	Immaturity alone, or primary to diseases other than early infancy (774, 776)	96	45	8	—	—	—	149
	Attributed to maternal toxaemia (769) ..	6	2	—	—	—	—	8
	Ill-defined diseases of early infancy (773) ..	2	7	2	1	—	—	12
	Postnatal asphyxia and atelectasis (762) ..	62	61	6	2	—	—	131
	Intracranial and spinal injury at birth (760) ..	20	36	5	1	—	1	63
	Other birth injury (761)	2	—	—	—	—	—	2
	Erythroblastosis (770)	14	4	1	—	—	—	19
	Haemorrhagic disease of newborn (771) ..	2	5	2	—	—	—	9
Postnatal Group	Total causes mainly of postnatal origin ..	3	21	22	40	57	33	176
	Gastro-enteritis (including diarrhoea of newborn) (571, 764)	—	—	3	7	6	9	25
	Pneumonia and bronchitis (490–493, 763, 500–502)	—	20	12	21	36	12	101
	Other diseases of respiratory system (510–527)	1	—	1	—	3	—	5
	Causes classified as infective (001–138): others mainly infective in origin (340, 391–393, 480–483, 690–698, 765–768)	—	1	3	7	7	10	28
	Whooping cough (056)	—	—	—	1	—	2	3
	Influenza (480–483)	—	—	—	—	2	—	2
	Otitis media and mastoiditis (391–393)..	—	—	—	1	2	2	5
	Skin and subcutaneous tissue infections; sepsis of newborn (690–698, 765–768)..	—	1	2	2	—	—	5
	Tuberculosis, other than tuberculous meningitis (001–008, 011–019)	—	—	—	1	—	—	1
	Tuberculous meningitis (010)	—	—	—	—	—	1	1
	Meningococcal infections and non-meningococcal meningitis (057, 340) ..	—	—	1	2	2	5	10
	Causes classified as infective not specified above (remainder 001–138) ..	—	—	—	—	1	—	1
	Accidental mechanical suffocation from vomit, food, foreign body, or in cot (E921–E925)..	1	—	3	5	5	—	14
	Lack of care; neglect (including foundlings); infanticide (E926, E980–E985)	1	—	—	—	—	—	1
	Other accidental causes (remainder E800–E999)	—	—	—	—	—	2	2
Unclassified	Other remaining causes	6	1	4	1	5	12	29

Of the 718 children who died before reaching one year of age, 235 had died before they were a day old; 445 did not survive a week, and no fewer than 521, or 73 per cent. of the total, had died before they were four weeks old.

Of these early infant deaths, numerically the most important causes were immaturity (unqualified), asphyxia and atelectasis, congenital malformations, birth injury, and pneumonia and bronchitis in that order. At ages one month to 12 months the greatest risks lie in pneumonia and bronchitis, congenital malformations, gastro-enteritis, and accidental suffocation through inhalation of food or otherwise.

As the number of deaths after the first week of life is declining perinatal mortality assumes relatively greater importance. This is the term used to describe the combination of stillbirths with deaths occurring during the first week of life. The line between stillbirth and early neo-natal death is not easily defined, and a higher stillbirth rate at one time might be associated with lower neo-natal mortality, and vice-versa, as is the case this year. On the death certificates of no less than 24 infants the period of gestation was given as under 28 weeks, by far the majority of infants living no longer than a few hours.

The following table shows the perinatal mortality rate and the death rate of infants aged one week and over since 1947:—

	1947	1948	1949	1950	1951	1952	1953	1954	1955	1956
Perinatal mortality (per 1,000 total births)	42·2	39·2	40·0	39·2	41·3	41·0	39·8	41·1	40·8	39·5
Infant deaths at one week and over (per 1,000 total births)	27·1	23·0	21·4	18·6	15·6	12·9	13·4	12·1	11·1	10·1

It will be seen that, apart from the slight increase in 1953, the death rate of infants between one week and one year has fallen progressively, but the perinatal rate has remained fairly stable and certainly gives no indication of any substantial reduction.

The outstanding problem of perinatal death is premature birth; half the total number of stillbirths and two-thirds of the deaths in the first week of life weighed 5½ lbs. or under at birth. The solution of the problem lies with research and studies in this country and abroad are proceeding. Amongst known causes are the toxaemias of pregnancy and early recognition of these conditions and prompt treatment can effect a substantial saving in infant life.

Deaths

The total number of deaths registered and allocated to the Administrative County was 19,105—an increase of 218 compared with 1955. The crude death rate was 11·8 per thousand population, fractionally higher than that for 1955 (11·7) yet less by the same fraction than the rate for 1954 and the average of the 5 years 1951 to 1955.

Crude death rates, although based on actual occurrences, do not give a true comparative mortality index. The age and sex distribution of the population varies from area to area, and of two areas or districts the one containing the larger proportion of elderly people almost certainly will have the higher crude death rate, although the environmental conditions may be far better than in the other. In order to compare more accurately the mortality factors operating in an area with those of other areas and with the country as a whole, an adjustment to the crude rate is necessary which makes allowances for the differing constitution of the population.

The adjusted rates from all causes for the past six years for the Administrative County, the aggregates of Boroughs and Urban Districts, Rural Districts, also the rates for England and Wales are as follows:—

Year	Boroughs and Urban Districts	Rural Districts	Administrative County	England and Wales
1951	13·6	11·9	13·2	12·5
1952	12·3	10·8	12·0	11·3
1953	12·6	10·4	12·1	11·4
1954	12·8	11·4	12·5	11·3
1955	12·7	11·0	12·3	11·7
1956	13·1	12·0	12·9	11·7

The results of advances in medical science and improved environmental conditions, although contributing much towards a decrease in the death rate, are being offset by the effects of the ageing of the population. As this ageing process continues there will be increasingly less room for further contraction in the death rate. The death rates in age groups show a rapid decline from the high mortality in infancy to a minimum in the age group 5–14 years. After that there is an increase in the rates gradual at first but becoming more pronounced at higher ages, and it must cause concern that 28 per cent. of all deaths should be people of working age—deaths which can be ill-afforded.

The following table shows, in age groups, the deaths in 1956 and in each of the previous ten years:—

	Age at Death								
	Under 1 year	1 and under 5	5 and under 15	15 and under 25	25 and under 45	45 and under 65	65 and under 75	75 and over	Total
1946	1,304	204	166	322	1,222	4,265	4,952	5,487	17,922
1947	1,462	242	192	305	1,238	4,331	5,236	5,713	18,719
1948	1,129	206	149	268	1,133	4,207	4,975	5,582	17,649
1949	1,037	191	166	247	1,049	4,396	5,545	6,419	19,050
1950	904	161	126	211	943	4,245	5,450	6,751	18,791
Ave. 5 years 1946–50	1,167	201	160	271	1,117	4,289	5,231	5,990	18,426
Percentage of Total Deaths	6·3	1·1	0·9	1·5	6·0	23·3	28·4	32·5	100·0
1951	798	175	135	206	964	4,521	5,853	7,553	20,205
1952	736	123	100	153	873	4,254	5,146	6,887	18,272
1953	733	120	104	185	835	4,349	5,188	6,990	18,504
1954	677	101	109	153	834	4,382	5,388	7,435	19,079
1955	645	115	115	155	807	4,347	5,381	7,322	18,887
Ave. 5 years 1951–55	718	127	113	170	863	4,370	5,391	7,237	18,989
Percentage of Total Deaths	3·8	0·7	0·6	0·9	4·5	23·0	28·4	38·1	100·0
1956	718	101	110	148	745	4,454	5,341	7,488	19,105
Percentage of Total Deaths	3·8	0·5	0·6	0·8	3·9	23·3	27·9	39·2	100·0

Child Mortality

Deaths of children aged 1 and under 5 years numbered 101, which is equivalent to a rate of 1·05 per 1,000 children in that age group. These figures compare favourably with those of the previous year and the number of deaths, the same as in 1954, is the lowest ever recorded. When compared with the average for forty to forty-five years ago the reduction in mortality is remarkable. In the period 1911 to 1915 roughly 1 in every 9 deaths was of a child in this age group; in 1956 the ratio was 1 in 190.

During the period covered by the following table many of the causes which once were responsible for much loss of life have been virtually eliminated, but far too many deaths to-day are caused by accidents. Motor vehicle accidents were responsible for the death of 12 children and, as will be seen from the table on page 17, home accidents, many of which are preventable, take an unnecessary toll of life.

The table below gives, for certain periods, the number of deaths of children aged 1–5 years from the various causes and the death rates per 1,000 children living in the age group in the Administrative County:—

Cause of Death	Annual Averages for Quinquennia						1955	1956
	1911–15	1927–31	1935–39	1940–44	1945–49	1950–54		
Measles	439	107	27	18	10	4	4	1
Whooping cough	167	67	29	20	11	5	1	2
Diphtheria	110	47	51	32	5	1	—	—
Other infective and parasitic diseases, excl. Tuberculosis	54	45	18	13	7	9	7	5
Tuberculosis, respiratory	47	13	5	4	4	1	—	—
Tuberculosis, other	201	82	37	39	30	11	3	3
Cancer	3	5	4	6	4	9	12	7
Heart and circulatory diseases	4	3	2	1	1	—	—	1
Influenza	6	43	10	11	4	2	—	—
Pneumonia	457	321	121	85	42	19	11	14
Bronchitis	150	42	10	17	9	6	5	7
Other diseases of respiratory system	49	15	6	5	3	2	4	1
Diarrhoea and other digestive diseases	248	45	38	23	17	4	6	2
Congenital debility, malformations	12	9	7	10	12	13	20	8
Accidents	82	54	50	47	38	27	24	30
Other causes	323	119	52	45	30	23	18	20
All causes	2,352	1,017	467	376	227	136	115	101
Death rate per 1,000 living in the age group	17·13	10·62	5·09	4·17	2·23	1·29	1·17	1·05

Principal Causes of Death.—The increasing preponderance of elderly people in the population governs to a large extent the relative order of frequency of the principal causes of death. As in recent years the chief causes of death were heart disease, cancer and vascular lesions of the nervous system (cerebral hæmorrhage). These three causes account for more than all the other classified causes put together, while deaths due to infectious disease are of relatively negligible proportions. The table below shows the number of deaths in 1956 allocated to the Administrative County classified to age and cause:—

Cause of Death	Age at Death—Years								
	Under 1 year	1 and under 5	5 and under 15	15 and under 25	25 and under 45	45 and under 65	65 and under 75	75 and over	Total
1. Tuberculosis, respiratory	—	—	—	5	35	78	45	14	177
2. Tuberculosis, other	2	3	1	2	5	9	2	3	27
3. Syphilitic disease	—	—	—	—	4	27	15	11	57
4. Diphtheria	—	—	—	—	—	—	—	—	—
5. Whooping cough	3	2	—	—	—	1	—	—	6
6. Meningococcal infections	4	3	1	—	—	—	1	—	9
7. Acute poliomyelitis	—	—	1	1	—	—	—	—	2
8. Measles	—	1	—	—	—	—	—	—	1
9. Other infective and parasitic diseases	1	2	2	1	6	11	6	5	34
Total—Infective and Parasitic Diseases excl. Tuberculosis	*8*	*8*	*4*	*2*	*10*	*39*	*22*	*16*	*109*
10. Malignant neoplasm, stomach	—	—	—	—	20	173	179	129	501
11. Malignant neoplasm, lung, bronchus	—	—	—	—	27	288	151	53	519
12. Malignant neoplasm, breast	—	—	—	—	28	126	76	47	277
13. Malignant neoplasm, uterus	—	—	—	—	15	80	32	18	145
14. Other malignant and lymphatic neoplasms	—	3	13	4	75	526	469	463	1,553
15. Leukaemia, aleukaemia	—	4	11	4	7	18	17	10	71
Total—All forms of Cancer	—	*7*	*24*	*8*	*172*	*1,211*	*924*	*720*	*3,066*
16. Diabetes	—	1	1	—	7	32	57	40	138
17. Vascular lesions of nervous system	1	—	4	6	32	509	930	1,527	3,009
18. Coronary disease, angina	—	—	—	—	69	894	1,098	899	2,960
19. Hypertension with heart disease	—	—	—	2	3	78	177	211	471
20. Other heart disease	—	1	2	5	72	363	699	1,822	2,964
21. Other circulatory disease	—	—	—	1	11	114	200	509	835
Total—Heart and Circulatory Diseases	—	*1*	*2*	*8*	*155*	*1,449*	*2,174*	*3,441*	*7,230*
22. Influenza	2	—	1	—	5	31	25	46	110
23. Pneumonia	74	14	4	3	15	92	166	293	661
24. Bronchitis	27	7	2	1	15	298	372	420	1,142
25. Other diseases of respiratory system	5	1	1	—	11	61	55	40	174
Total—Diseases of the Resp. Sys. incl. Influenza and excl. Tuberculosis	*108*	*22*	*8*	*4*	*46*	*482*	*618*	*799*	*2,087*
26. Ulcer of stomach and duodenum	—	—	—	1	8	51	42	45	147
27. Gastritis, enteritis and diarrhoea	25	2	3	4	1	14	13	18	80
28. Nephritis and nephrosis	1	5	3	9	30	63	67	58	236
29. Hyperplasia of prostate	—	—	—	—	—	6	30	77	113
30. Pregnancy, childbirth, abortion	—	—	—	4	10	—	—	—	14
31. Congenital malformations	120	8	6	6	9	9	1	2	161
32. Other defined and ill-defined diseases	436	14	17	31	80	268	279	506	1,631
33. Motor vehicle accidents	—	12	15	25	43	46	27	20	188
34. All other accidents	16	18	22	26	68	90	76	186	502
35. Suicide	—	—	—	7	32	94	33	16	182
36. Homicide and operations of war	1	—	—	—	2	4	1	—	8
Total—Accidents, Suicide and Violence	*17*	*30*	*37*	*58*	*145*	*234*	*137*	*222*	*880*
Total—All Causes	718	101	110	148	745	4,454	5,341	7,488	19,105

Tuberculosis.—Deaths from all forms of tuberculosis numbered 204, compared with 192 in 1955 and the average of 302 for the years 1951–55. The death rate from the disease was 0·13 per thousand of the population, compared with 0·12 for the previous year and with the average of 0·19. For a considerable time mortality ascribed to tuberculosis has continuously declined decade by decade with the exception of the setbacks during the two world wars and in the years immediately following the second.

Almost 87 per cent. of the deaths in 1956 were due to the respiratory forms of the disease—177 with a resultant death rate per 1,000 of the population of 0·11, the same as the rate for 1955 based on 169 deaths. Deaths from other forms of tuberculosis numbered 27, 4 more than in 1955, resulting in a fractional increase in the death rate from 0·01 to 0·02.

The mortality from the disease now tends to be higher at the older ages and does not now cause so much loss of young life, indeed in 1956 there were only 6 deaths in children under the age of 15 years.

The encouraging situation which has become apparent in recent years should not be regarded as an excuse for any relaxation of effort in rigorously applying all measures at our disposal for combating the disease.

Infective and Parasitic Diseases.—This group, as now classified, consists of the principal epidemic diseases together with certain contagious diseases and replaces the zymotic classification in operation prior to 1950.

The number of deaths allocated to these various causes was 109, compared with 105 in 1955 and 120 in 1954. More than half these deaths were from syphilitic disease, and whilst it is regrettable that the number of deaths from this disease is not decreasing as rapidly as one would wish, it is gratifying that since 1951 no death of a child under 1 year of age has been attributable to the disease. There were 6 deaths from whooping cough, 3 more than the previous year, but this increase is more than offset by the reduction from the remaining diseases. For the second year in succession there was no death from diphtheria.

Cancer.—The total deaths from cancer, including leukaemia, numbered 3,066, equivalent to a death rate of 1·89 per 1,000 population.

To-day one death in every six is certified as cancer and, although better diagnostic facilities have contributed, the steady increase in mortality over the years has been due for the most part to the ageing population bringing more people into the age groups most susceptible to the disease. It seems more than likely that as the ageing process continues mortality will tend to increase progressively.

The number of deaths according to the site and sex for the past seven years is given in the following table:—

Year		Stomach	Lung, Bronchus	Breast	Uterus	Other Malignant and Lymphatic Neoplasms	Leukaemia, Aleukaemia	Total, All Sites
	M.	294	280	1	—	820	30	1,435
1950	F.	290	57	250	142	725	19	1,485
	P.	584	337	251	142	1,545	49	2,908
	M.	302	302	—	—	855	26	1,485
1951	F.	228	58	253	166	636	31	1,372
	P.	530	360	253	166	1,491	57	2,857
	M.	358	335	—	—	899	30	1,622
1952	F.	218	60	284	157	681	32	1,432
	P.	576	395	284	157	1,580	62	3,054
	M.	298	381	5	—	811	33	1,528
1953	F.	242	63	283	156	680	38	1,462
	P.	540	444	288	156	1,491	71	2,990
	M.	349	404	1	—	886	29	1,669
1954	F.	264	61	285	172	719	40	1,541
	P.	613	465	286	172	1,605	69	3,210
	M.	301	393	2	—	842	46	1,584
1955	F.	214	72	305	153	684	40	1,468
	P.	515	465	307	153	1,526	86	3,052
	M.	298	439	5	—	773	38	1,553
1956	F.	203	80	272	145	780	33	1,513
	P.	501	519	277	145	1,553	71	3,066

As will be seen from the foregoing table, our statistics have shown decided changes in sex and site trends. Cancer of the stomach has relinquished its position as leading site of malignant growth to lung and bronchus with the remaining sites maintaining their relative positions. Deaths from cancer of the stomach in females show an improvement which is not apparent in males.

The greatest increase in any separate site is in lung and bronchus, especially in males. Much has been written and said about the statistical relationship between excessive cigarette smoking and lung cancer, also the deleterious effect of atmospheric pollution, and while there may be other factors, at present unknown, operating, it is in our own interests that these two main suspects should be recognised and eliminated where possible. Local authorities are playing their part in the reduction of atmospheric pollution, but excessive cigarette smoking, with its attendant risk, is a personal addiction which would be best left to the decision of the individual.

Vascular Lesions of Nervous System.—The 3,009 deaths classified to vascular lesions of the nervous system (cerebral hæmorrhage, etc.) represent slightly less than 16 per cent. of total deaths. Although there were 49 less than in the previous year, the number of deaths in 1956 from this cause was 174 greater than the average for the years since 1950 when the revised classification became operative. As with other diseases which are associated with middle and old age, mortality from the disease tends to increase, and it is likely that the improvement in 1956, although welcome, is only temporary. Of the 3,009 deaths nearly a third of them were of persons between the ages of 65 and 74, while a half were aged 75 years or over. Although at ages under 45 years mortality is slightly heavier in males, from then on there is a preponderance of female deaths.

Heart and Circulatory Diseases.—Compared with 1955, mortality from this group of diseases increased by 155 to a total of 7,230, and resulted in an equivalent death rate of 4·47 per 1,000 population. In total the deaths amounted to 38 per cent. of deaths from all causes. The majority of deaths were, of course, of elderly people, only 166 being under 45 years of age.

The number of deaths from separate causes tends to fluctuate from year to year, yet a definite trend has emerged in respect of coronary disease, including angina. The death rate from this cause, with the exception for 1955, has progressively increased, so that the rate for 1956 was 43 per cent. higher than that for 1950. A feature of the deaths was the preponderance of males; at ages under 45 years the death rates were small and, although based on a small number of deaths, the male to female ratio was nearly 4 : 1. In the age group 45 to 64 years the ratio fell to 3 : 1, followed by 1·5 : 1 in the 65 to 74 years group and only 1·05 : 1 for persons 75 years and over.

Deaths classified as being due to other heart disease numbered 2,964, which, although only 25 less than in 1955, is substantially less than the average of 3,394 for the years since 1950, when the revised classification was introduced. Since 1951 the death rate per 1,000 population has progressively decreased, and while the improvement indicates a downward trend it should be accepted with reserve.

The number of deaths and the mortality rates per 1,000 of the population in each of the years 1950-56 are as follows:—

Year	Coronary disease, angina		Hypertension with heart disease		Other heart disease		Other circulatory disease		Total	
	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate
1950	2,037	1·28	495	0·31	3,751	2·36	698	0·44	6,981	4·39
1951	2,234	1·41	511	0·32	4,017	2·53	733	0·46	7,495	4·72
1952	2,370	1·49	376	0·24	3,482	2·19	691	0·43	6,919	4·35
1953	2,364	1·49	404	0·25	3,330	2·09	684	0·43	6,782	4·26
1954	2,736	1·71	472	0·30	3,222	2·01	839	0·52	7,269	4·54
1955	2,721	1·69	503	0·31	2,989	1·86	862	0·54	7,075	4·39
1956	2,960	1·83	471	0·29	2,964	1·83	835	0·52	7,230	4·47

Diseases of the Respiratory System.—Deaths from this group of diseases—influenza, pneumonia, bronchitis and other diseases of the respiratory system, numbered 2,087, compared with 1,955 in the previous year. The principal individual causes were bronchitis 1,142 (1,109 in 1955), pneumonia 661 (602), and influenza 110 (73).

As for heart and circulatory diseases, this group also has a higher death rate for males as compared with females; for influenza the ratio is approximately the same, but for the remaining diseases the male preponderance is pronounced, especially in bronchitis, which is about 2 : 1.

As is usual with these diseases, the age at death tends to follow a set pattern with mortality being high in infants under 1 year, falling to negligible proportions in school children and early adult life, thereafter progressively increasing, indeed over two-thirds of the deaths were of persons aged 65 years or over.

Maternal Mortality.—Deaths from these causes, including abortion, numbered 14, giving a rate per 1,000 live and still births of 0·52, compared with 0·56 for England and Wales. The County rate is only a fraction above that for 1953, the lowest ever recorded.

A maternal death is now becoming a comparatively rare event. Remarkable advances have been made in better ante-natal care and in medical science, so much so that there was only one maternal death per 1,935 births.

The table below shows the number of deaths and the mortality rate for the past 28 years for the Administrative County:—

Year	No. of deaths			Mortality Rate per 1,000 live and still births		
	Puerperal and post abortive sepsis	Other maternal causes	Total	Puerperal and post abortive sepsis	Other maternal causes	Total
1929	58	76	134	2·16	2·83	4·99
1930	63	99	162	2·32	3·64	5·96
1931	57	88	145	2·19	3·37	5·56
1932	50	77	127	1·96	3·01	4·97
1933	48	96	144	1·98	3·96	5·94
1934	54	82	136	2·20	3·33	5·53
1935	43	62	105	1·78	2·56	4·34
1936	39	61	100	1·62	2·54	4·16
1937	21	69	90	0·87	2·87	3·74
1938	25	62	87	1·03	2·55	3·58
1939	19	51	70	0·79	2·13	2·92
1940	22	53	75	0·92	2·21	3·13
1941	17	48	65	0·68	1·93	2·61
1942	25	59	84	0·96	2·27	3·23
1943	18	46	64	0·68	1·72	2·40
1944	18	40	58	0·60	1·32	1·92
1945	14	32	46	0·53	1·20	1·73
1946	14	41	55	0·46	1·34	1·80
1947	7	36	43	0·21	1·07	1·28
1948	3	31	34	0·10	1·05	1·15
1949	4	19	23	0·15	0·68	0·83
1950	*	*	26	*	*	0·98
1951	*	*	24	*	*	0·93
1952	*	*	20	*	*	0·80
1953	*	*	13	*	*	0·51
1954	*	*	22	*	*	0·89
1955	*	*	17	*	*	0·67
1956	*	*	14	*	*	0·52

* Deaths from puerperal and post abortive sepsis are no longer given separately.

With the decline in puerperal sepsis, toxaemia and haemorrhage have become the two major causes of maternal mortality, and evidence points to these two conditions playing a large part in the cause of stillbirths and neo-natal deaths.

A revised international classification of deaths came into operation in 1950, and the following table gives the maternal mortality rates per 1,000 live and still births for the Administrative County and England and Wales for the years 1951 to 1955 inclusive. The figures for 1956 are not yet available.

Cause of Death	1951		1952		1953		1954		1955	
	W.R. Admin. County	England and Wales	W.R. Admin. County	England and Wales	W.R. Admin. County	England and Wales	W.R. Admin. County	England and Wales	W.R. Admin. County	England and Wales
Maternal sepsis (not associated with abortion)	0·12	0·10	—	0·09	0·08	0·10	0·04	0·09	0·12	0·11
Toxaemias of pregnancy and puerperium (not associated with abortion)	0·12	0·24	0·32	0·21	0·16	0·24	0·16	0·19	0·12	0·16
Abortion with or without mention of sepsis or toxaemia	0·23	0·16	0·12	0·13	0·04	0·11	0·36	0·11	—	0·10
Other complications of pregnancy, childbirth and the puerperium	0·46	0·32	0·36	0·29	0·23	0·30	0·32	0·30	0·44	0·27
Total Maternal Mortality	0·93	0·82	0·80	0·72	0·51	0·75	0·89	0·70	0·67	0·64

Violence.—Deaths from this group of causes totalled 880, compared with 879 in 1955 and 809 in 1954. In 1956, 690 deaths were from accidents and 182 from suicide; the remainder were caused by homicide and late effects of war operations.

The cause of deaths from violence during the past three years is indicated in the following table:—

Year	Motor Vehicle Accidents	Accidents in the Home	All other Accidents	Suicide	Homicide and operations of war	Total Accidents, Suicide, Homicide
1954	167	238	236	157	11	809
1955	177	240	267	183	12	879
1956	188	244	258	182	8	880

There has been a steady but irregular increase recently in the number of deaths from motor vehicle accidents, mortality being heavier among males, but in no particular age group. Other deaths by accident have been divided according to place of accident, in the home or elsewhere. As usual, deaths in the home in 1956 make up the greatest individual group of fatalities. They numbered 244, which is well in excess of the number of deaths attributed to many causes, for which a separate classification is provided. The causes of death from accidents in the home are shown below:—

Cause of Death		Age at Death						
		Under 1 year	1–	5–	45–	65–	75 and over	Total
Accidental poisoning by solid and liquid substances.	M.	—	—	1	2	—	—	3
	F.	—	—	1	1	2	1	5
Accidental poisoning by gases and vapours	M.	—	—	2	—	—	3	5
	F.	1	—	1	2	—	11	15
Accidental falls	M.	—	3	2	3	13	30	51
	F.	—	—	1	6	26	92	125
Accidents caused by burns and scalds	M.	—	—	1	—	1	5	7
	F.	—	1	5	2	3	3	14
Accidental mechanical suffocation	M.	10	—	2	—	—	—	12
	F.	3	—	—	—	—	—	3
Accidental drowning and submersion	M.	—	—	—	—	—	—	—
	F.	—	1	—	—	—	1	2
Other and unspecified accidents	M.	1	—	—	1	—	—	2
	F.	—	—	—	—	—	—	—
Total	M.	11	3	8	6	14	38	80
	F.	4	2	8	11	31	108	164

Accidental falls were the main cause, accounting for 176 deaths, or 72 per cent. of the total deaths through accidents at home. Deaths from falls were far more numerous among females, with the heaviest toll (90 per cent.) being of persons aged 65 years or over.

The second highest cause was burns and scalds which caused 21 deaths. Accidental poisoning by gases and vapours caused 20 deaths, the majority being from coal gas poisoning, and of elderly people some of whom had turned the gas on but, unfortunately, either through being interrupted or momentary loss of memory, had failed to light it.

Accidental mechanical suffocation accounted for 15 deaths, 13 of which were children under 1 year. Of these 13 deaths, 6 were due to suffocation in bed or cradle and the remainder to inhalation of food or vomit.

The prevention of home accidents is a matter of concern to everyone. It is a tragedy to-day, when advances in certain fields have done much to reduce the incidence of disease, that mortality from home accidents continues to increase. Non-fatal accidents, many of them leading to serious or permanent disability, are probably also more numerous and, paradoxically, the gains that have been made have decreased infant mortality and extended the expectation of life of the elderly, the two age groups most susceptible to home accidents.

PART II

EPIDEMIOLOGY

Incidence and Notification of Infectious Disease

Smallpox, *cholera*, *diphtheria*, *membranous croup*, *erysipelas*, *scarlet fever*, and the fevers known by any of the following names, *typhus*, *typhoid*, *enteric*, or *relapsing*, are compulsorily notifiable under Section 144 of the Public Health Act, 1936; *chicken-pox* is notifiable under Section 147 of the same Act in some West Riding County Districts; *food poisoning* under Section 26 of the Food and Drugs Act, 1955. The following communicable diseases are compulsorily notifiable under the regulations stated in brackets—*measles and whooping cough* (Measles and Whooping Cough Regulations, 1940); *meningococcal infection*, *acute poliomyelitis—paralytic and non-paralytic*, *and acute encephalitis—infective and post infectious* (Acute Poliomyelitis, Acute Encephalitis and Meningococcal Infection Regulations, 1949); *ophthalmia neonatorum* (Ophthalmia Neonatorum Regulations, 1926, 1928 and 1937); *puerperal pyrexia* (Puerperal Pyrexia (Amendment) Regulations, 1954); *tuberculosis* (Tuberculosis Regulations, 1952); *malaria*, *dysentery and acute primary and influenzal pneumonia* (Infectious Diseases Regulations, 1953); *plague* (Notification of Case of Plague (General) Regulations, 1900). The contagious diseases of syphilis, gonorrhoea and soft chancre (classed under the term venereal diseases) and scabies are not compulsorily notifiable.

The following table shows the number of cases in 1956 of each "notifiable" disease, being the numbers of cases originally notified and the final numbers after corrections subsequently made by the notifying medical practitioner or by the Infectious Diseases Consultant, because of revised diagnosis as a result of bacteriological reports or further observation of cases since notification:—

AGE GROUP	Scarlet Fever		Whooping Cough		Acute Poliomyelitis (Paralytic)		Acute Poliomyelitis (Non-paralytic)		Measles		Diphtheria		Dysentery		Meningococcal Infection	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified (All Ages)	746	765	2,076	2,195	26	16	23	15	1,625	1,656	—	—	1,635	1,368	36	42
	1,511		4,271		42		38		3,281		—		3,003		78	
Final numbers after correction																
Under 1 year	2	10	205	193	—	1	—	—	75	66	—	—	47	38	7	6
1—2 years	9	13	194	197	2	3	—	—	161	141	—	—	76	61	5	4
2—3 ,,	52	36	225	274	1	—	—	—	166	192	—	—	97	85	2	7
3—4 ,,	73	65	283	256	2	—	2	—	222	198	—	—	76	62	—	5
4—5 ,,	87	88	288	328	—	1	1	—	249	228	—	—	85	72	2	1
5—9 ,,	351	402	812	870	7	2	4	5	692	755	—	—	440	383	2	3
10—14 ,,	110	116	45	38	3	1	2	1	37	50	—	—	151	95	6	2
15—24 ,,	34	18	2	4	—	5	5	2	14	17	—	—	72	87	1	4
25 and over	11	11	14	31	2	5	3	3	7	5	—	—	341	333	8	6
Age unknown	5	3	3	3	—	—	—	—	2	4	—	—	47	37	—	—
Total (all ages)	734	762	2,071	2,194	17	18	17	11	1,625	1,656	—	—	1,432	1,253	33	38
	1,496		4,265		35		28		3,281		—		2,685		71	

AGE GROUP	Acute Pneumonia		Smallpox		Acute Encephalitis (Infective)		Acute Encephalitis (Post-infectious)		Enteric or Typhoid Fever		Paratyphoid Fevers		Erysipelas		Food Poisoning	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified (All Ages)	636	466	—	—	2	1	1	2	1	—	7	8	98	89	150	514
	1,102		—		3		3		1		15		187		664	
Final numbers after correction																
Under 5 years	82	75	—	—	—	—	—	1	—	—	—	1	1	—	28	20
5—14 years	62	44	—	—	2	—	—	1	1	—	4	4	5	2	20	189
15—44 ,,	154	100	—	—	—	—	—	—	—	—	2	3	21	26	20	236
45—64 ,,	205	119	—	—	—	1	—	—	—	—	—	—	48	44	14	15
65 and over	130	119	—	—	—	—	—	—	—	—	—	—	19	13	5	12
Age unknown	3	5	—	—	—	—	—	—	—	—	—	—	3	4	11	2
Total (all ages)	636	462	—	—	2	1	—	2	1	—	6	8	97	89	98	474
	1,098		—		3		2		1		14		186		572	

	Numbers originally notified	*Numbers after correction*
Puerperal Pyrexia	98	98
Ophthalmia Neonatorum ..	13	13
Chicken-pox	474†	Not corrected
Malaria	2	2

† Chicken-pox is compulsorily notifiable only in certain County Districts .

The table below affords a comparison with the preceding eight years:—

Disease	*Number of corrected notifications (Chicken-pox not corrected)*								
	1948	1949	1950	1951	1952	1953	1954	1955	1956
Scarlet Fever	3,863	3,191	2,506	1,792	2,176	2,991	1,993	1,633	1,496
Whooping Cough	6,201	3,947	7,669	6,933	5,865	5,821	3,252	3,112	4,265
Diphtheria	153	66	32	10	4	1	4	—	—
Measles	16,545	16,489	15,763	25,194	13,938	19,853	5,558	29,357	3,281
Acute Pneumonia (primary or influenzal)	1,308	1,456	1,207	1,739	1,366	1,585	1,144	1,121	1,098
*Meningococcal Infection	*56*	*60*	55	57	50	37	41	39	71
Acute Poliomyelitis (paralytic)	52	250	150	90	103	101	44	244	35
Acute Poliomyelitis (non-paralytic)			41	58	28	25	20	86	28
*Acute Encephalitis (infective)	*1*	*2*	6	5	6	7	4	2	3
*Acute Encephalitis (post infectious)	—	—	3	14	1	3	4	4	2
Dysentery	208	73	1,117	837	370	455	1,454	1,310	2,685
Ophthalmia Neonatorum	51	37	39	29	23	20	17	15	13
Puerperal Pyrexia	98	98	125	128	151	141	131	136	98
Smallpox	—	—	—	—	—	14	—	—	—
Enteric or Typhoid Fever (excluding Paratyphoid)	18	3	9	—	2	2	5	5	1
Paratyphoid Fever	10	11	4	62	4	10	30	25	14
Erysipelas	409	429	405	312	273	302	307	263	186
†Chicken-pox	432	827	465	797	1,350	739	694	370	474
§Malaria	6	2	1	2	5	14	9	2	2
‡Food Poisoning	‡	329	346	138	192	329	276	346	572
Tuberculosis:									
Respiratory	1,246	1,478	1,297	1,296	1,337	1,223	1,084	1,033	837
Other Forms	407	431	348	285	296	247	206	205	182
Total (Tuberculosis)	1,653	1,909	1,645	1,581	1,633	1,470	1,290	1,238	1,019

*These terms replace others in use before 1st January, 1950, for certain groups of diseases and are consistent with the international standard classification of diseases, which was brought into general use on 1st January, 1950. More or less, the term "meningococcal infection" covers the same disease as the former term "cerebro-spinal fever", but also covers a somewhat wider group of diseases; "acute encephalitis (infective)" replaces the former term "encephalitis lethargica"; "acute encephalitis (post infectious)" covers the forms of encephalitis occasionally following or associated with certain well defined infections, e.g., chicken-pox, measles, mumps and vaccinia and is to bring about the notification of cases showing late effects of acute encephalitis (infective). The figures in italics in the above table show the number of cases notified under the former terms.

† Chicken-pox is compulsorily notifiable only in certain County Districts, and the figures given do not, therefore, represent the full number of cases occurring in the Administrative County.

§ All the cases of malaria shown in the above table were believed to be contracted abroad.

‡ Notification of cases of food poisoning, or suspected food poisoning, only became generally in operation as from 1st January, 1949.

Scarlet Fever

There was a further decrease in the incidence of scarlet fever during the year. The number of corrected notifications was 1,496, 137 less than in 1955 and, apart from the total of 1,314 cases notified in 1918, it is the lowest ever recorded.

As is usual, the greatest number of cases arose during the first and fourth quarters of the year in children under 5 years of age. The disease continues to be comparatively mild and the majority of cases respond quickly to treatment.

The attack rate per 1,000 of the population for the Administrative County was 0·92 compared with 0·74 for England and Wales. The highest incidence was experienced in the following County Districts: Penistone U.D. 4·10; Mexborough U.D. 4·01; Rothwell U.D. 2·71; Knottingley U.D. 2·33; Meltham U.D. 2·33; Cudworth U.D. 2·28; Ilkley U.D. 2·26; Ripon and Pateley Bridge R.D. 2·01.

Whooping Cough

After two years of relatively low incidence there was a considerable increase in notifications of whooping cough from 3,112 in 1955 to 4,265 in 1956.

A feature of the notifications was that there was no appreciable variation between the sexes; in the past there has been a preponderance of females but for 1956 notifications relating to females only amounted to 51 per cent. of the total. The age distribution closely followed that recorded in the previous year, 96·7 per cent. of the cases being under 10 years of age.

In recent years mortality from the disease has declined remarkably; in 1946 there were 41 deaths; in 1956, 6; but it should be remembered that, although the disease in itself is not highly fatal, secondary infection may be responsible for much ill-health as well as some mortality.

The 4,265 cases notified represent an attack rate of 2·64 per thousand of the population (1·93 in 1955) compared with 2·07 (1·78 in 1955) for England and Wales. The disease was most prevalent in the following County Districts: Meltham U.D. 20·62; Silsden U.D. 9·12; Sedbergh R.D. 8·90; Osgoldcross R.D. 8·33; Penistone U.D. 6·07; Colne Valley U.D. 6·06; Queensbury and Shelf U.D. 5·83; Castleford M.B. 5·63; Stocksbridge U.D. 5·62; Shipley U.D. 5·50.

Immunisation against Whooping Cough.—The Authority's scheme for whooping cough immunisation remained unchanged from previous years, a single vaccine being provided at the Authority's expense. 11,298 children under 4 years of age were immunised during the year and since the commencement of the scheme in 1952, a total of 43,663 children have been immunised.

Over the last few years, numerous requests have been made that the Authority should make available a combined diphtheria/whooping cough vaccine, primarily because of the fewer number of injections needed to protect a child against both diseases than when separate antigens are given. These requests have been resisted, as it was felt that no change should be made until such time as the Ministry of Health expressed an opinion on the results of the trials which have been proceeding in the use of combined vaccines. It is thought that the Ministry will be advising Local Health Authorities in the near future, not on the results of the trials, but as a result of evidence which has come to light, on the relation between the incidence of poliomyelitis and immunisation procedures generally.

During the year, the Medical Research Council Committee on Inoculation Procedures and Neurological Lesions reported their findings. Briefly these findings indicate that the risk associated with individual antigens in respect of paralysis provoking effects is much less than when combined antigens are used, being greatest with alum precipitated diphtheria–whooping cough vaccine. The single whooping cough vaccine as used by the Authority was reported on as being relatively safe.

Diphtheria

From 1935 to 1939 the average annual number of notifications of diphtheria was about 2,460. During the same period the number of deaths showed an irregular but substantial fall to a level of around 100. Since 1941, the reduction in both notifications and deaths has been dramatic and it is very satisfactory being able to report that for the second successive year there was no notification in the Administrative County.

A small outbreak of *C. diphtheriae gravis* occurred in a school in Wakefield C.B. at which a number of West Riding children attend. Four West Riding children were found to be carriers and suitable precautions were taken to prevent the spread of the disease in their homes. The carrier state persisted for some time but finally responded to treatment.

The table below, which covers the period of highest and lowest incidence, indicates the enormous saving of child life, illness, parental anxiety and hospital beds which has been achieved.

Year	Number of corrected notifications	Number of deaths	Year	Number of corrected notifications	Number of deaths
1935	3,175	209	1946	551	17
1936	2,261	150	1947	221	4
1937	2,337	138	1948	153	9
1938	2,560	142	1949	66	5
1939	1,983	95	1950	32	1
1940	1,896	110	1951	10	—
1941	1,996	104	1952	4	—
1942	1,686	85	1953	1	—
1943	1,539	75	1954	4	2
1944	1,130	49	1955	—	—
1945	862	30	1956	—	—

Diphtheria Immunisation.—The number of children who received immunisation during 1956, together with figures for previous years, are shown in the following table:—

Year	No. of children who completed a full course of immunisation			No. of children who were given a re-inforcing injection
	Under 5	5—14	Total	
1948	20,958	6,220	27,178	19,274
1949	20,728	7,162	27,890	18,071
1950	14,836	3,961	18,797	13,929
1951	16,606	5,567	22,173	17,092
1952	15,798	5,298	21,096	23,390
1953	13,768	4,893	18,661	22,614
1954	15,207	5,013	20,320	22,515
1955	13,566	4,516	18,082	18,663
1956	14,874	4,367	19,241	18,130

Although the total of 19,241 is a slight increase on that for 1955, it cannot be regarded as satisfactory. In spite of propaganda and the persuasive efforts of the health visitors, many parents continue to show considerable apathy towards immunisation. There is no doubt that this is due to the almost complete absence of the disease over most of the country in recent years and it is a difficult task to convince some parents that the maintenance of a high level of immunity amongst the child population is the best means of ensuring that the incidence of diphtheria is kept at its present low level. It is significant that at the 31st December, 1956, only 2,623 children who were under one year of age at that date had been immunised, out of a total of 25,600 (10 per cent.). The aim should still be the immunisation of at least 75 per cent. of children before they attain their first birthday.

It is a comparatively simple matter to arrange for the immunisation of children when they once commence attendance at school, when the overall immunisation state of the child population begins to improve. This is readily seen in the following table from which it will be noted that at the end of the year 75·2 per cent. of all children aged 0–14 inclusive had been immunised at some time previously.

Number Immunised

Year	Under 5	Percentage of population under 5	5–14	Percentage of population 5–14	Total under 15	Percentage of population under 15
1948	59,795	44·1	139,194	65·0	198,989	56·9
1949	64,811	46·7	143,966	65·8	208,777	58·4
1950	66,484	47·9	150,179	67·1	216,663	59·7
1951	66,077	47·4	150,177	70·1	216,254	61·5
1952	60,885	46·4	177,875	74·8	238,760	64·7
1953	54,304	42·9	198,151	81·4	252,455	68·2
1954	55,990	45·2	217,052	87·5	273,042	73·4
1955	53,180	43·6	224,126	88·3	277,306	73·8
1956	53,147	43·6	233,120	90·2	286,267	75·2

Measles

Reference has been made in previous Reports to the biennial epidemicity of measles and, following the highest recorded total of 29,357 notifications in 1955, it was to be expected that 1956 would be a year of low incidence. Corrected notifications numbered 3,281, the lowest number notified since 1946.

Measles is usually more prevalent during the winter months and 1956 was no exception. The epidemic of 1955 was practically spent by the end of the year and notifications in the first quarter of 1956 were few. As the year progressed the number of notifications fluctuated but remained low until October when the 1956/57 cycle commenced. 1,885 notifications were received in the fourth quarter of the year, 1,016 arising in December thus indicating that 1957 probably will be a year of high incidence.

The virulence of the measles virus has been declining throughout the country for several decades but since 1940, when the disease first became compulsorily notifiable, the percentage ratio of deaths to notifications in the Administrative County has varied from year to year. In 1956 the percentage ratio was 0·03 which compares favourably with that for England and Wales which was also around 0·03.

The pattern of incidence closely followed that of previous years in that it was low in the first year of life but increased rapidly thereafter up to school age. It is almost a truism that everyone contracts measles and, like whooping cough, it is principally dangerous through its complications. Fortunately, with modern drugs, the complications which previously led to much chronic ill-health and mortality are often preventable and generally curable.

During the year the disease was especially prevalent in the South of the County, the following County Districts experiencing the highest incidence per 1,000 of the population: Penistone R.D. 18·44; Bentley with Arksey U.D. 18·35; Knottingley U.D. 15·47; Stocksbridge U.D. 11·63; Adwick le Street U.D. 11·21; Normanton U.D. 10·40; Hemsworth U.D. 10·30; Doncaster R.D. 8·15; Thorne R.D. 8·05.

Meningococcal Infection

There has been an irregular but steady fall in the number of notifications of meningococcal infection for a number of years and it is disappointing having to report an increase in incidence. Corrected notifications numbered 71 as compared with 39 in 1955 and an average of 47 during the years since 1950 when the revised group classification was introduced.

The tendency of recent years to an increased proportion of notifications and a high fatality ratio in children under 5 years of age has continued. There does not, however, appear to be any indication of the disease changing its mildly endemic pattern to an epidemic one.

Acute Poliomyelitis

In 1956, a total of 63 confirmed notifications was received (35 of the paralytic and 28 non-paralytic form) which was substantially below the average yearly incidence experienced since the disease became one of major importance in this country in 1947. Unlike some diseases, the incidence of poliomyelitis does not appear to follow any cyclic pattern but it is noteworthy that, following the epidemic year of 1947 in which 400 confirmed notifications were received, only 52 cases were notified in 1948 so that the considerable reduction in notifications from 330 in 1955 was not unexpected.

A feature of the cases in 1956 was the ratio of paralytic to non-paralytic forms. Since 1950, when the non-paralytic form became separately notifiable, the ratio has varied between 1·6 : 1 and 4·0 : 1; in 1956 it was 1·3 : 1. The sex ratio also fluctuates from year to year. For a number of years the disease has attacked more males than females and 1956 saw no exception in that 54 per cent. of the cases were males, but with no marked preponderance in any particular age group. The age incidence of the cases notified was very similar to that of previous years with 60 per cent. of the cases occurring in children under 15 years of age.

Clinically, most of the cases were mild and although a few persons were left with residual paralysis by far the majority recovered to lead their normal lives.

The proportion of multiple cases in the same family was higher than usual. In one family, three out of the five children were affected; in another, two children and in a third the mother and daughter.

Notifications were comparatively numerous in Saddleworth U.D. with 9 cases and a resultant attack rate of 0·54 per thousand population, but on the whole the cases were sporadic.

Vaccination against Poliomyelitis.—In January, 1956, the Ministry of Health issued Circular 2/56, containing proposals for arrangements to be made through Local Health Authorities for vaccination against poliomyelitis. The Circular indicated that a British vaccine had now been discovered which it was believed would confer a degree of protection against paralytic poliomyelitis and that supplies in limited quantities would become available for use in May and June before the start of the poliomyelitis season. At the outset, vaccination was to be offered to the parents of all children born between 1947 and 1954 inclusive.

A scheme on the lines suggested by the Ministry was approved by the Health Committee in February, 1956.

There were in the West Riding Administrative Area some 209,000 eligible children and a printed leaflet and form of consent was sent to the parent of every known child in the age group and simultaneously announcements of the scheme were made in local newspapers to cover those children whose names were not already known. In the case of school children, the leaflets were issued through the schools by co-operation with the Head Teachers. In the case of children under five years of age, the leaflets were issued through the infant welfare centres, or delivered by hand by the health visitors, or sent through the post.

Of the 209,000 eligible children, the parents of 64,213 (30 per cent.) gave their written consent to vaccination. Details of the children (sex, year, and month of birth) were returned to the Ministry in April. As supplies of vaccine were limited, the Ministry advised Local Health Authorities of those children who were to be vaccinated as each batch of vaccine was released and vaccinations commenced in May. Also owing to the limitation of supplies the Ministry stated that general medical practitioners would not be able to take part in the scheme in the initial stages and the vaccinations were, accordingly,

undertaken by the Divisional Medical Officers and the Assistant County Medical Officers at schools or at clinic premises. By the time vaccinations were suspended at the end of June, 6,214 children had received two injections and so completed their vaccination, and 583 children had reeeived one injection. The scheme was re-commenced at the end of November after the poliomyelitis season when vaccine was made available for those children who had reeeived one injection only earlier in the year. Thus, by thc end of the year, of the 64,213 originally registered, 6,797 had been vaccinated, leaving 57,416 still to be vaccinated.

Acute Encephalitis

Only 5 eases of the disease wcre eonfirmed during the year, 3 infeetive and 2 post-infectious, which compares favourably with the incidence of previous years.

Thc three infective cases arose in widely separated distriets and although the post-infectious notifications camc from the same County District thcre was no apparent connection betwecn the two cases. The post-infectious form is usually a eomplieation associated with one of the commoner infectious diseases—measles, mumps or chickcn-pox and in the two eases reported the primary illness was mumps.

Dysentery

Notifications of dysentery in 1956 were the highest on record. In all 2,685 eases wcre confirmed, compared with 1,310 in 1955 and 1,454 in 1954 the previous highest recorded total. There has been a considerable increase in the disease since the end of the war and, while making allowances for more efficient notification, there is no indication yet that peak figures have been reached.

Corrected notifieations in 1956 by quarters and by sex were as under:

	M	F.	Total
First Quarter ..	459	437	896
Seeond Quarter ..	418	347	765
Third Quarter ..	171	162	333
Fourth Quarter ..	384	307	691

Sinee dysentery became notifiable in 1919 there have been ehanges in the character and incidence of the disease. In recent years it has been brought about by the ability of the Sonne strain to spread through the community producing symptoms usually unpleasant but mild and having a low fatality ratio. The majority of the eases in 1956 were of the Sonne strain and it is suggested that the disease which was at one time thought to be spread by a combination of food-borne infeetion and personal contact has practically ceased to be a food-borne menace and has adopted the far more successful method of spread by person to person. Further support for this view is to be found in the absence of a rise in notifications in autumn which is a characteristie of the food-borne diseases.

For some time the importanee of the sehool as an epidemic centre has been noted with the younger school children being primarily involved, spread being most likely effected through close eontact and lack of personal hygiene. Mild undetected cases as well as the symptomless excreters also contribute.

It will be noted from the table on page 18 that 26 per eent. of the notifications related to children under 5 years of age, 30 per eent. in the age group 5—9 years with deereasing proportions at higher ages. When the incidence per 1,000 living in the agc group is considered there is little difference in the rates for children of pre-school age and the 5—9 age group, both are slightly less than 6; followed by a rate of 2 per thousand for the 10—14 years group and negligible rates at other ages.

If we are to eombat this disease the focus of our activities should be on the primary departments of schools. Outbreaks in sueh departments are beeoming more frequent and while therc appears to be some association between the school calendar and the incidenee of the disease the figures for the County are too small to draw any reliable conclusions. In some instances it seems that the main epidemic is curtailed by the break-up of schools, re-gaining momentum when the new term begins. Whether there is a true fall in incidence during school holiday periods or whether the absence of supervisory staff, e.g., school teachers, and consequential absence of ascertainment of cases and contacts plays a great part rcquires consideration. The absence of supervisory staff may be the reason for the low incidence during the months of August and early September.

There is much still to be learned about Sonne Dysentery and its increasing prevalenee makes a continued study of the disease more than ever neeessary. The Public Health Laboratory Service Committee on Sonne Dysentery has continued its investigations but the importance of absolute eleanliness, both personal and in the preparation and handling of food, together with the proper cleansing of the hands by all immediately after using the w.c. remain our chief safeguards against the disease.

Commenting on a typical outbreak in his Division, Dr. J. M. Watt, Division No. 31, writes:

"There was an outbreak of Sonne Dysentery in the Aston, Aughton, Swallownest and Catcliffe districts which began in the middle of September and finished three months later. The first cases occurred in Aston Infants' School and the infection was spread quickly by older children in the same families to the Aston Lodge Junior School and Swallownest Senior School. Infection did not break out in the Catcliffe district until a month later. There were a few scattered cases in the surrounding districts of Treeton, Ulley, Thurcroft and Dinnington. The peak period of the outbreak was in the middle of October when 62 cases were ascertained in one week.

There was a total of 357 cases of dysentery of which 80 occurred in adults, 94 in pre-school children and 183 in school children. Diagnosis was established by laboratory report or by the fact that other proved cases had occurred in the same household. Close contact was kept with the family doctors who were given all laboratory reports immediately and who sent in 136 notifications.

The symptoms of the infection were diarrhoea for three or four days, intestinal colic and, in a proportion of cases, vomiting. There were no deaths from the infection.

Spread in the great majority of cases appeared to be by touch and there was no evidence of any kind that cases were due to food infection.

The weekly incidence of cases was as follows:—

Week Ending	*Cases*
15.9.56 ..	3
22.9.56 ..	13
29.9.56 ..	31
6.10.56 ..	57
13.10.56 ..	62
20.10.56 ..	52
27.10.56 ..	26
3.11.56 ..	29
10.11.56 ..	19
17.11.56 ..	27
24.11.56 ..	19
1.12.56 ..	9
8.12.56 ..	6
15.12.56 ..	4
Total	357

SUMMARY OF CASES

Schools	*Number of Cases*	
Aston Infants	52	
Aston Lodge Juniors	34	
Swallownest Seniors	44	
Swallownest Juniors and Infants ..	6	
Aughton Juniors and Infants ..	14	
Catcliffe Infants	19	
Catcliffe Seniors	4	
Treeton Infants	1	
Thurcroft Modern	1	
Ulley School	1	
Woodhouse Grammar	1	
Dinnington Technical	1	
Laughton Juniors and Infants ..	2	
Doncaster Deaf School	1	(infection occurred at his home in Swallownest)
	181	
Other Cases		
'Danes Hill' Children's Home ..	3	(including one adult)
Pre-School Children	94	
Adults	79	
Total ..	357	

METHODS OF CONTROL

All school children with dysentery were excluded for a fortnight. Paper towels were supplied by the Education Department to six schools and were used before the midday meal after a routine washing of hands.

The school caretakers were interviewed and were very successfully persuaded to start a special effort to keep the cloak-rooms, school furniture, water closets and urinals clean. All school kitchen staffs in the area had laboratory tests and three were found to be dysentery carriers. These three women were suspended from work until their infectious condition was cleared. In the school most severely affected, the teaching staff co-operated willingly in having laboratory tests also. Two school teachers were found to have infection and were excluded from school.

Three food handlers were found to be cases or carriers and were excluded from work.

Two children in 'Danes Hill' Children's Home were admitted to Lodge Moor Isolation Hospital with dysentery infection and one of the members of the household staff was also found to have the infection. All the remaining children and the household staff at 'Danes Hill' had laboratory tests which proved to be negative.

Two Health Visitors made approximately a thousand visits to the homes to detect cases and carriers and to advise parents upon the procedure necessary to clear up family infections."

Ophthalmia Neonatorum

Ophthalmia neonatorum is defined in the Regulations as "a purulent discharge from the eyes of an infant commencing within 21 days from the date of its birth". Prompt, skilled treatment is required if impaired vision or even total blindness is to be avoided. Since 1950 the number of notifications has fallen progressively and the total for 1956 of 13 cases is the lowest ever recorded. In none was vision impaired.

Puerperal Pyrexia

After the new regulations re-defining puerperal pyrexia as "any febrile condition occurring in a woman in whom a temperature of 100·4°F (38°C) or more has occurred within fourteen days after childbirth or miscarriage" came into operation in 1951 there was a marked but irregular increase in notifications. The number of cases notified in 1956, 98, is appreciably lower than the previous year and compares favourably with an average of 137 in respect of the years in which the revised regulations have been in force.

Smallpox

For the third year in succession no case of smallpox was recorded in the Administrative County. While this may be a source of satisfaction we should not allow complacency to prevail. Absence of the disease soon engenders apathy on the part of the parents and makes more difficult the task of persuading them that if the country is to be kept free from this still serious and often fatal disease a high level of vaccination must be maintained.

Vaccination Against Smallpox.—Vaccination is offered to the parents or guardians of all children during the early months of life and is carried out either by the family doctor at the surgery or at the home, or by the Medical Officer at the Infant Welfare Clinic.

The following table shows the number of vaccinations and re-vaccinations performed during the years 1953–56:

Year	Vaccinations						Re-Vaccinations					
	Under 1	1	2–4	5–14	15 or over	Total	Under 1	1	2–4	5–14	15 or over	Total
1953	6,556	2,901	6,770	24,611	29,166	70,004	12	58	842	8,680	36,266	45,878
1954	5,379	1,019	351	424	797	7,970	—	1	44	245	1,238	1,528
1955	6,329	1,294	376	282	612	8,893	1	8	56	163	1,226	1,454
1956	6,892	983	348	317	582	9,122	6	4	47	215	1,300	1,572

One case of generalised vaccinia was reported. The condition responded to oral penicillin.

Enteric (Typhoid) Fever

Only one case of enteric fever was notified during the year, in Tadcaster R.D. The case was a boy from a residential school for maladjusted pupils, who had spent part of his summer holiday at a holiday resort. Shortly after his return to school the boy was taken ill and later admitted to hospital. Dr. R. G. Smithson, the Medical Officer of Health, made thorough investigations and advised on the preventive measures necessary. Fortunately it proved to be an isolated case.

Paratyphoid Fever

Of the 14 corrected notifications of paratyphoid fever received during the year 8 were from Shipley U.D. and 3 from Rotherham R.D.

The following comments on the cases from Shipley U.D. have been supplied by Dr. J. Battersby, the Medical Officer of Health:

"On 17.10.56 a girl aged 8 was admitted to Leeds Road Infectious Diseases Hospital from the Bradford Children's Hospital as a Paratyphoid Fever. She had been ill for ten days with headache and sickness, particularly on the 11th and 12th. Pain was not prominent and there was no diarrhoea, blood or slime motion.

Contacts were immediately visited, and it was ascertained that three other children were ill, again with indeterminate symptoms. The children had attended a party at the home of one on 6.10.56.

General Practitioners were notified and it was soon evident that other cases were infected: indeed, a total of eight cases arose.

Items of diet which came under suspicion were potted meat and buttercream from a nearby shop. Other foods were eliminated, as were parties on other dates around the occasion. Specimens from the personnel from the shop concerned were examined and one man was found to be a carrier of Paratyphoid B. Our investigations were complicated as, unfortunately, the organism was untypeable, whereas in all the other cases the culture belonged to phage type 2. A considerable range of products was examined, including egg albumen, synthetic cream, dried egg powder, Chinese frozen egg, as well as cream cakes prepared in the home of one of the patients.

Clinical manifestations were extremely mild; indeed, one woman patient showed no symptoms whatsoever, nor did she give any history of illness. All recovered.

There was the usual surfeit of false clues and although the outbreak was throughly investigated the cause, unfortunately, remains unproven."

The 3 cases in Rotherham R.D. arose in the same family. A little boy was diagnosed in hospital as having the disease and the notification was made by Sheffield C.B. On subsequent enquiries it was found that the father, a daughter and another son also had the disease. In spite of intensive investigations by the Medical Officer of Health and his staff it was not possible to ascertain how the original infection was introduced.

The remaining notifications were single ones which had no apparent connection.

Food Poisoning

It is disappointing once again to record a further increase in the number of cases of food poisoning. The number of corrected notifications was 572, in addition to which 33 cases were ascertained during the course of investigations but were not notified making a total of 605, the highest number since notification came into general use in 1949. The actual number of cases probably was much greater for there may have been a considerable number of mild cases which did not receive medical attention and, consequently, do not appear in the records.

The relevant statistics for 1956 are given in the following table:

Division No.	Food Poisoning Notifications returned to R.G. (corrected)					Number of outbreaks due to Identified Agents						Outbreaks of Undiscovered Cause		Single Cases		
	Quarter of Year				Total	Chemical Poisoning	Salmonella Organisms	Staphylococci (inc. Toxin)	Cl. Botulinum	Other Bacteria	Total Cases	No. of Outbreaks	No. of Cases	Agent Identified	Unknown Cause	Total
	1st	2nd	3rd	4th												
1	—	6	4	1	11	—	2	—	—	—	8	—	—	1	2	3
2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
3	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
4	1	—	10	2	13	—	—	—	—	—	—	—	—	13	—	13
5	—	4	1	—	5	—	—	—	—	—	—	—	—	2	3	5
6	2	4	22	1	29	—	1	—	—	—	15	—	—	4	10	14
7	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
8	3	1	1	322	327	—	—	—	—	1	322	—	—	4	1	5
9	—	1	4	—	5	—	—	—	—	—	—	1	4	1	—	1
10	—	—	—	2	2	—	—	—	—	—	—	1	2	—	—	—
11	—	—	8	—	8	—	2	1	—	—	7	—	—	1	—	1
12	—	—	—	4	4	—	—	—	—	—	—	—	—	4	—	4
13	—	—	6	—	6	—	—	—	—	—	—	—	—	6	—	6
15	—	—	—	3	3	—	—	—	—	—	—	—	—	3	—	3
16	—	1	2	—	3	—	—	1	—	—	33†	—	—	—	3	3
17	—	5	4	—	9	—	—	—	—	—	—	—	—	4	5	9
18	—	1	8	5	14	—	1	—	—	—	6	—	—	5	3	8
19	3	—	3	1	7	—	—	—	—	—	—	—	—	3	4	7
20	—	1	13	5	19	—	3	—	—	—	11	1	2	5	1	6
22	4	7	2	19	32	—	3	—	—	1	20	2	10	1	1	2
23	—	9	3	—	12	—	—	—	—	—	—	—	—	12	—	12
25	2	—	1	1	4	—	—	—	—	—	—	—	—	4	—	4
26	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
27	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
28	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
29	2	—	2	—	4	—	—	—	—	—	—	—	—	1	3	4
30	—	1	—	1	2	—	—	—	—	—	—	—	—	2	—	2
31	40	4	9	—	53	—	1	1	—	—	7	1	38	2	6	8
	57	45	103	367	572	—	13	3	—	2	429	6	56	78	42	120

† 33 cases not notified but ascertained during the course of investigations.

Although outbreaks were thoroughly investigated by the Medical Officers of Health and their staffs it was not always possible to discover the cause of the poisoning but where investigations were successful three types of organisms were found mainly to be responsible—the Salmonella group, Clostridium welchii and Staphylococcal toxin.

The number of outbreaks including family outbreaks in which the causal agent was identified was 18 involving 429 cases; outbreaks of undiscovered cause numbered 6 with 56 cases; 120 single cases were notified, in 78 of which the agent responsible was ascertained.

Of the total cases, 322 arose at a girls' boarding college. Feeding is on a communal basis and for supper one evening the majority of girls and staff had shepherds pie, the meat for which had been cooked the previous day, made-up and re-heated. Approximately 6 to 8 hours after those who had eaten the pie had violent attacks of diarrhoea and subsequently Cl. welchii A was isolated. The

desirability of eating food as soon as possible after it has been cooked and the avoidance of re-heating meat dishes cannot be stressed too strongly if we are to eliminate the risk involved with this type of infection.

By far the majority of the family outbreaks and sporadic cases were caused by Salmonella organisms which indicates the widespread infection caused by the lack of personal hygiene.

Much food poisoning is preventable and everyone, caterers, food handlers and housewives alike can play their part in ensuring that all foodstuffs are handled hygienically, prepared and stored in such a way that they are really safe to eat. The coming into operation of the Food Hygiene Regulations, 1955, will strengthen the hands of local authorities in dealing with matters of standards of hygiene and objectionable habits, but unless the general public will co-operate in their own interests, progress towards the eradication of the disease will be restricted. If we could only educate the public to pay more attention to the need for scrupulous cleanliness of hands and utensils, to cook at temperatures which are lethal to bacteria, to use sound meat only and to prefer freshly cooked food to re-heated dishes, we should do much to prevent the disease. Unfortunately public apathy is the greatest enemy of progress in the drive for clean, safe food. In spite of sustained efforts in many of the County Districts where clean food campaigns have been organised Officers have found that they have almost always been preaching to the converted. The people we wish to reach most by way of health education are always the most difficult to contact.

Influenza

Although influenza is not statutorily notifiable, statistics from various sources indicate that the incidence of the disease was not unduly high.

There was an appreciable seasonal increase in upper respiratory infections during January and February and high absentee rates were experienced in schools in certain areas.

A few sporadic cases of virus A influenza were confirmed but there was no apparent outbreak.

Tuberculosis

Deaths from Tuberculosis.—There were 204 deaths from tuberculosis (177 respiratory and 27 non-respiratory), an increase of 8 respiratory and 4 non-respiratory over the previous year and representing a death rate of 0·13 (0·11 respiratory and 0·02 non-respiratory). This may be compared with the England and Wales death rates of 0·12 (0·11 respiratory and 0·01 non-respiratory) and too much significance should not be attached to the small increase in deaths which are still the second lowest recorded in any year in the County. A more favourable feature, and one on which comment was made in last year's Report, is the decreasing proportion of deaths from tuberculosis in persons under 45 years of age. This trend continues with the 53 deaths under 45 years of age, representing 26 per cent. of the total as compared with 29 per cent. in the previous year. Details of the deaths are given in the following table:

Classification	Age at Death in Years																Total		Grand Total
	0—		1—		5—		15—		25—		45—		65—		75—				
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Respiratory	—	—	—	—	—	—	1	4	21	14	65	13	36	9	12	2	135	42	177
Non-respiratory	2	—	1	2	—	1	1	1	1	4	4	5	—	2	2	1	11	16	27
Totals	2	—	1	2	—	1	2	5	22	18	69	18	36	11	14	3	146	58	204

Notification of Tuberculosis.—There were 1,019 primary notifications of tuberculosis arising during the year and 31 supplemental notifications, a total of 1,050 as compared with 1,238 (1,198 primary and 40 supplemental) notifications in 1955. Details of the new cases are summarised in the following table:

	AGE PERIODS													Total all Ages
FORMAL NOTIFICATIONS:	0—	1—	2—	5—	10—	15—	20—	25—	35—	45—	55—	65—	75—	
Respiratory, Males	—	3	13	7	10	36	50	78	74	82	89	40	12	494
Respiratory, Females	2	—	7	11	13	47	53	92	49	29	22	13	5	343
Non-respiratory, Males ..	3	4	13	12	10	11	6	8	6	9	2	3	2	89
Non-respiratory, Females ..	—	3	5	18	13	7	6	11	10	10	5	3	2	93
														1,019
SUPPLEMENTAL NOTIFICATIONS:														
Respiratory, Males	—	—	—	—	—	—	—	—	1	1	7	6	5	20
Respiratory, Females	—	—	—	—	—	—	—	1	2	1	5	—	—	9
Non-respiratory, Males ..	—	—	—	—	—	—	—	—	—	1	—	—	—	1
Non-respiratory, Females ..	—	—	—	—	—	—	—	—	—	—	—	—	1	1
														31

The sources of information of the supplemental notifications were Local Registrars (22 respiratory and 1 non-respiratory); transferable deaths from the Registrar General (6 respiratory and 1 non-respiratory) and 1 posthumous notification of the respiratory form of the disease.

For the past decade, the spotlight has been focused on the dramatic reduction in the death rate from tuberculosis, and concern has been expressed at the absence of a correlated decline in incidence as measured by new notifications of cases suffering from the disease. Indeed, in the early years, there was some increase in notifications, which reached its peak in 1949, a phenomenon no doubt associated with the advance in successful treatment in that energies were released to search out new cases, including a wider range of contacts, to diagnose and to treat and so to prevent the further spread of infection. There has been a subsequent gradual diminution until in 1953 the number of primary notifications (1,415) fell below the number recorded in 1947 (1,448). This seemed to be the turning point and the succeeding years have now brought evidence for sober confidence. In the decade there have been 14,290 primary notifications of the disease but only 45 per cent. of these are recorded in the latter half of the period. The 1,019 primary notifications of 1956 show a 15 per cent. reduction on those for the previous year and a 44 per cent. reduction on the peak year of 1949. An examination of the figures relating to the respiratory forms of the disease shows the familiar picture of a preponderance of male over female sufferers from the disease. Although true in total, this disparity is due almost entirely to the age groups of 45 and over. In the past 10 years, there have been 4,121 primary notifications of males as compared with 4,134 females under 45 years of age, a feature which is repeated in last year's notifications of 271 males and 274 females of the same age groups. The reason for the apparently greater incidence in the older men remains obscure. Despite the increasing tendency for women to remain at or to return to work, it is perhaps still true, and particularly at that age group, to suggest that men are more exposed to the hazards of sporadic infection by virtue of their employment and, indeed, of their recreational habits, although there are few who would suggest that in modern conditions a housewife's work is less strenuous than that of her husband. It may be equally true that the policy of case finding, particularly by the concentration of mass radiography facilities for factory examinations, is more likely to produce the man rather than the woman for examination. In the latter event, it may be that the remaining unknown source of infection is to be found amongst the housewives whose domestic chores do not enable them to go out to regular factory work or permit of leisure time sufficient for them to co-operate in mass radiography surveys.

Posthumous Notifications.—The following table gives the result of enquiries which have been made to determine the reason why there had been a failure to notify the 31 cases, the supplemental notifications, before the death of the patient.

1. Information Obtained from Local Registrars' Death Returns.

Patient			Cause of Death	Remarks
Sex	Age	Resp. or Non-Resp.		
F	56	Resp.	1(a) Acute Haemorrhage lt. kidney. (b) Stone and Pyeloncphritis. 2 Miliary tuberculosis rt. lung.	Not considered to be suffering from active pulmonary tuberculosis during her period in mental hospital . . . post-mortem examination stated "both lungs present some evidence of *old* tuberculous disease, more marked on the rt. side". She was X-rayed (1955)—no further investigation advised.
F	58	Resp.	1(a) Myocardial failure. (b) Arteriosclerosis. 2 Pulmonary tuberculosis.	According to mental hospital records, a notification that the patient was suffering from tuberculosis was sent to the Medical Officer of Health in 1952. There is no record of it ever having been received by the Medical Officer of Health.
M	74	Resp.	Pulmonary tuberculosis. Haemoptysis.	Certified by Deputy Coroner after post-mortem without inquest.
M	57	Resp.	1(a) Secondary carcinoma. (b) Bronchial carcinoma. 2 Pulmonary tuberculosis.	This man was admitted to Sanatorium for investigation and the presence of tuberculosis was only confirmed after post-mortem.
M	74	Resp.	1(a) Carcinoma of bronchus. 2 Pulmonary tuberculosis.	Both conditions diagnosed at chest clinic 5 months before death. T.B. notification was overlooked due to advanced carcinoma.
F	53	Resp.	1(a) Myocardial failure. (b) Hypertension. 2 Chronic pulmonary tuberculosis.	Not discovered until after post-mortem examination.
F	44	Resp.	Bilateral pulmonary tuberculosis. Bilateral broncho-pneumonia.	Not discovered until after post-mortem examination.
M	75	Resp.	1(a) Degenerated vascular disease. 2 Silicosis with tuberculosis.	Diagnosis not made until after post-mortem examination. Patient lived alone. Neighbour who looked after him was urged to attend chest clinic for a follow-up examination.
M	57	Resp.	Silicosis with tuberculosis.	Diagnosis not made until after post-mortem examination; home contacts visited and arrangements made for them to attend Chest Clinic. N.A.D.
M	75	Resp.	Silicosis with tuberculosis.	Diagnosis not made until after post-mortem examination. Patient lived alone for 13 years. Step-daughter who lived nearby was visited and advised to attend Chest Clinic but did not wish to do so.
F	62	Resp.	1(a) Pulmonary oedema (b) Right left sided cardiac failure. (c) Pulmonary tuberculosis.	Investigation has revealed that the patient was notified in 1931, was removed from the Register in 1946 as "lost sight of" and was never restored to the register.
F	64	Resp.	Pulmonary tuberculosis.	Died in mental hospital.
M	70	Resp.	Pulmonary tuberculosis due to pneumoconiosis; myocardial degeneration.	Found at post-mortem. (Industrial disease). All contacts checked.
F	84	Non-Resp.	(a) Cardiovascular degeneration. (b) Tuberculosis of pelvis. Thrombophlebitis of L. leg.	Died in mental hospital.
F	37	Resp.	(a) Pulmonary tuberculosis. (b) Cerebral diplegia.	Died in mental hospital
M	44	Resp.	(a) Pulmonary tuberculosis. Broncho-pneumonia. (b) Phthisis.	Died in mental hospital.
F	30	Resp.	Haemoptysis due to pulmonary tuberculosis.	All contacts checked.
M	65	Resp.	Pulmonary tuberculosis due to pneumoconiosis (industrial disease).	All contacts checked.
M	64	Resp.	Congestive cardiac failure due to Cor Pulmonale, due to pulmonary tuberculosis and silicosis.	All contacts checked.

Patient			Cause of Death	Remarks
Sex	Age	Resp. or Non-Resp.		
M	82	Resp.	Pulmonary tuberculosis and the industrial disease of pneumoconiosis.	Cause of death ascertained by post-mortem.
M	54	Resp.	1(a) Pulmonary tuberculosis. (b) Malnutrition following gastrectomy for gastric ulcer.	Was under observation.
M	81	Resp.	1(a) Cachexia. (b) Chronic pulmonary tuberculosis.	Was under observation.
M	73	Resp.	Pulmonary embolism due to femoral thrombosis due to pulmonary pneumoconiosis with superimposed pulmonary tuberculosis.	Discovered at post-mortem.

II. Information Obtained from Registrar General's Transferable Deaths.

Patient			Cause of Death	Remarks
Sex	Age	Resp. or Non-Resp.		
M	52	Non-Resp.	1(a) Renal failure. (b) Renal tuberculosis. 2 Lt. nephrectomy for tuberculosis.	—
M	55	Resp.	1(a) Carcinoma of urethra. 2 Pulmonary tuberculosis.	—
M	60	Resp.	Tuberculous broncho-pneumonia.	Found on post-mortem.
F	60	Resp.	1(a) Nephrosis. 2 Rheumatoid arthritis. Pulmonary tuberculosis.	Diagnosis of tuberculosis made in hospital where she had gone for treatment of rheumatoid arthritis and where she died.
M	77	Resp.	Pulmonary tuberculosis.	All contacts checked.
M	56	Resp.	1(a) Tuberculous ulceration of larynx. (b) Bilateral pulmonary tuberculosis.	Patient had not sought medical advice prior to admission to hospital where the tuberculous condition was diagnosed shortly before death. Contacts ascertained and referred to Chest Clinic.
M	64	Resp.	1(a) Internal haemorrhage. (b) Chronic gastric ulcer. (c) Pulmonary tuberculosis (active).	Was admitted to hospital with haemorrhage and died within 48 hours. Patient was a lodger and would not have a doctor until forced to. Contacts given appointment for X-ray, but no co-operation.

III. Information Obtained from Posthumous Notification.

Patient			Cause of Death	Remarks
Sex	Age	Resp. or Non-Resp.		
M	71	Resp.	1(a) Pulmonary tuberculosis. 2 Pernicious anaemia.	The registration of death on the weekly returns was the first and only intimation received. This patient had never attended at the Chest Clinic. All family contacts seen and invited to attend for chest X-ray at the Chest Clinic.

After adjustment for removals, recoveries and deaths, the total number of notified cases of tuberculosis on our register at the end of the year was 10,985, an increase of 206 compared with the previous year. The following table summarises the revision of the registers in the respective divisional areas:

Div. No.	Number of cases on register 1st January, 1956				Number of cases added to register				Number of cases removed from register				Number of cases remaining on register 31st December, 1956				Number of cases remaining on register	
	Respiratory		Non-Resp.		Respiratory		Non-Resp.		Respiratory		Non-Resp.		Respiratory		Non-Resp.		Total	Per 1,000 Pop'l'n
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
1	167	132	48	47	29	21	6	4	15	14	6	9	181	139	48	42	410	7·0
2	63	47	20	24	5	2	—	—	5	1	3	7	63	48	17	17	145	6·4
3	196	128	53	37	24	12	3	4	8	4	4	—	212	136	52	41	441	7·9
4	230	153	33	50	30	23	3	4	17	16	1	6	243	160	35	48	486	7·2
5	230	152	40	53	36	21	4	—	25	17	7	3	241	156	37	50	484	6·6
6	96	74	13	8	12	6	2	1	12	7	—	2	96	73	15	7	191	5·5
7	38	35	8	6	12	6	—	2	9	3	1	2	41	38	7	6	92	3·7
8	183	167	35	61	24	31	9	9	10	17	1	4	197	181	43	66	487	6·4
9	86	65	23	23	16	13	5	3	12	10	6	3	90	68	22	23	203	4·0
10	135	123	18	31	19	10	3	3	21	15	1	3	133	118	20	31	302	6·7
11	224	161	25	40	17	12	3	3	20	7	2	1	221	166	26	42	455	7·5
12	217	161	41	60	30	20	3	4	18	11	1	2	229	170	43	62	504	8·8
13	162	108	27	48	19	23	2	3	23	16	4	7	158	115	25	44	342	4·2
15	89	90	33	31	8	8	2	1	12	11	3	10	85	87	32	22	226	4·7
16	118	111	20	22	18	13	1	1	17	11	1	6	119	113	20	17	269	4·9
17	94	62	19	31	9	7	3	6	16	11	4	9	87	58	18	28	191	3·9
18	230	168	42	23	29	20	5	4	20	20	14	4	239	168	33	23	463	7·9
19	174	140	39	30	22	32	2	5	30	24	7	4	166	148	34	31	379	6·8
20	213	152	51	61	45	25	12	15	36	20	15	16	222	157	48	60	487	5·5
22	420	274	115	80	43	33	9	7	32	20	7	10	431	287	117	77	912	10·5
23	257	185	32	54	22	22	4	5	34	15	2	7	245	192	34	52	523	8·1
25	216	180	38	24	33	24	9	7	25	24	9	3	224	180	38	28	470	6·2
26	113	90	24	21	6	11	2	—	13	5	6	1	106	96	20	20	242	5·3
27	148	143	48	31	33	27	3	—	23	14	3	1	158	156	48	30	392	9·8
28	178	170	53	50	29	27	3	5	16	14	—	1	191	183	56	54	484	8·2
29	143	149	29	31	25	18	3	2	13	9	1	3	155	158	31	30	374	11·1
30	255	204	25	27	35	16	2	2	18	11	3	—	272	209	24	29	534	8·5
31	248	171	52	53	37	23	3	5	40	34	9	12	245	160	46	46	497	5·7
	4,923	3,795	1,004	1,057	667	506	106	105	540	381	121	136	5,050	3,920	989	1,026	10,985	6·8

Divisional Medical Officers have received 2,109 notifications (1,027 admissions and 1,082 discharges) relating to patients admitted to, or discharged from, treatment in 71 hospitals as follows:

INSTITUTION	Respiratory								Non-Respiratory							
	Admitted				Discharged				Admitted				Discharged			
	Adults		Children		Adults		Children		Adults		Children		Adults		Children	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Bradford Royal Infirmary	4	3	—	—	2	1	—	—	—	—	—	—	—	—	—	—
Bradley Wood Sanatorium, Huddersfield	24	12	—	—	27	11	—	—	—	—	—	—	—	—	—	—
Crimicar Lane Hospital, Sheffield	5	—	—	—	11	1	—	—	—	—	—	—	—	—	—	—
Crookhill Hall Hospital, Conisbrough	58	—	—	—	64	—	—	—	—	—	—	—	—	—	—	—
Doncaster Infectious Diseases Hosp. and Sanatorium	16	38	—	—	21	27	—	—	—	1	1	—	—	—	—	—
Gateforth Sanatorium, Hambleton, nr. Selby	89	—	1	—	77	—	1	—	—	—	—	—	1	—	—	—
Huddersfield Royal Infirmary	—	4	—	—	1	4	—	—	4	2	—	1	4	4	1	4
Killingbeck Hospital, Leeds	53	53	—	—	43	53	—	—	—	1	—	—	—	—	—	—
King Edward VII Hosp., Rivelin Valley Rd., Sheffield	—	—	—	—	—	1	—	—	5	3	3	5	8	7	1	4
Leeds Road Hospital, Bradford	—	4	—	—	—	8	—	—	—	—	—	—	—	—	—	—
Lodge Moor Hospital, Sheffield	3	—	—	—	7	—	—	—	1	—	—	—	—	—	—	—
Montagu Hospital, Mexborough	—	3	—	—	—	6	—	—	—	1	—	—	—	1	—	—
Northowram Isolation Hospital, Halifax	34	20	—	—	39	13	—	—	—	—	—	—	—	—	—	—
Oakwood Hall Sanatorium, Moorgate, Rotherham	24	17	—	—	26	21	2	—	—	—	—	—	—	—	—	—
Scotton Banks Hospital, Knaresborough	34	33	—	—	29	40	—	—	2	4	—	—	2	5	—	1
Seacroft Hospital, Leeds	2	—	5	5	7	1	2	5	1	—	1	—	—	—	2	—
Sheffield City General Hospital	4	5	—	—	3	5	—	—	—	—	—	—	—	—	—	—
Shelf Sanatorium, nr. Halifax	4	10	—	—	11	15	—	—	—	—	—	—	—	—	—	—
St. George's Hospital, Rothwell	—	9	—	—	—	13	—	—	—	—	—	—	—	—	—	—
St. Luke's Hospital, Bradford	6	2	1	—	2	2	1	—	—	2	1	—	—	1	1	—
The Hospital, Grassington, nr. Skipton	91	55	2	—	97	70	2	2	—	1	1	—	1	2	—	—
The Hospital, Middleton-in-Wharfedale, nr. Ilkley	55	24	9	4	68	39	6	4	8	7	4	3	6	9	7	3
Wath Wood Isolation Hospital, Wath-on-Dearne	28	20	—	—	22	22	2	—	—	—	—	—	—	—	—	—
Whitley Grange Hospital, Dewsbury	8	5	—	—	9	8	—	—	—	—	—	—	—	—	—	—
Winter Street Hospital, Sheffield	—	7	—	—	1	10	—	1	—	—	—	—	—	—	—	—
*Miscellaneous	30	14	3	2	21	9	2	1	4	5	9	4	1	2	4	1
	572	338	21	11	588	380	18	13	25	27	20	13	23	31	16	13

* The miscellaneous cases were under treatment at Ash House, Dore, Sheffield; Benenden Sanatorium, Kent; Bierley Hall Hospital, Bradford; Bradford Children's Hospital; Castle Hill Sanatorium, Cottingham; Chadderton Sanatorium, Lancs.; Clayton Hospital, Wakefield; Commonside Sanatorium, Sheffield; Connaught Military Hospital, Hindhead, Surrey; Dagenham Hospital, Essex; Dewsbury General Hospital; Doncaster Gate Hospital, Rotherham; Fairfield Hospital, York; Fielden Children's Hospital, Todmorden; Hyde Lodge Nursing Home, Clarendon Road, Leeds 2; Kendray Hospital, Barnsley; Kilton Hospital, Worksop, Notts.; Leeds General Infirmary; Marguerite Hepton Memorial Orthopaedic Hospital, Thorp Arch; Marsden Hospital, Burnley; Moorview Hospital, Meltham; Newstead Sanatorium, Fishpool, Mansfield; Oldham and District General Hospital; Papworth Hospital, Cambridge; Pinderfields Hospital, Wakefield; Preston Hall Hospital, Maidstone, Kent; Ransom Sanatorium, Rainworth, Notts.; Royal National Hospital, Ventnor, Isle of Wight; Royal Naval Hospital, Gosport, Hants.; Salts Hospital, Shipley; Scarborough Convalescent Home for Children; Scarborough Hospital; Sheffield Children's Hospital; Sheffield Royal Hospital; Sheffield Royal Infirmary; Snapethorpe Hospital, Wakefield; Staincliffe Hospital, Dewsbury; Strinesdale Sanatorium, Oldham; St. Alfege's Hospital, London S.E.10; St. James's Hospital, Leeds; St. Luke's Hospital, Huddersfield; Thornbury Annexe, Sheffield; Westmorland Sanatorium, Meathop, Grange-over-Sands; Westwood Hospital, Bradford; Wharncliffe Hospital, Wadsley, Sheffield; Wrightington Hospital, Appley Bridge, near Wigan.

PART III

DIVISIONAL ADMINISTRATION

Reference was made in my last Annual Report to the policy of reducing the number of Health Divisions as and when the opportunity arose, after consultation with the County District Councils concerned. The death of two Divisional Medical Officers occurred during the year and negotiations are proceeding for the two divisions affected to be amalgamated with neighbouring divisions.

The table below gives details of the divisions, population, acreage and the names and addresses of Divisional Medical Officers at 31st December, 1956.

Div. No.	County Districts	Population (Estimated Mid 1956)	Acreage	Divisional Medical Officer	Address of Divisional Health Office	Telephone Number
1	Barnoldswick U.	10,800	2,764	M. Hunter	Water Street, Skipton	Skipton 2438/9
	Earby U.	5,190	3,519			
	Silsden U.	5,370	7,101			
	Skipton U.	13,100	4,211			
	Skipton R.	24,090	146,071			
	Totals:	58,550	163,666			
2	Bowland R.	4,890	83,327	M. Hunter (Acting)	County Police Station, Cragdale, Settle	Settle 2205
	Sedbergh R.	3,820	52,674			
	Settle R.	14,080	152,087			
	Totals:	22,790	288,088			
3	Keighley B.	55,540	23,611	H. M. Holt	3 Bow Street, Keighley	Keighley 2244/5
4	Baildon U.	10,740	2,831	J. Battersby	P.O. Box No. 24, Town Hall, Shipley	Shipley 51363
	Bingley U.	21,660	11,418			
	Denholme U.	2,620	2,536			
	Shipley U.	32,200	2,183			
	Totals:	67,220	18,968			
5	Pudsey B.	31,460	5,323	H. M. Mitchell (Acting)	The Green, Horsforth	Horsforth 2252
	Aireborough U.	27,450	6,856			
	Horsforth U.	14,280	2,706			
	Totals:	73,190	14,885			
6	Ilkley U.	17,250	8,610	J. Battersby (Acting)	Boroughgate, Otley	Otley 2727
	Otley U.	11,300	2,934			
	Wharfedale R.	6,230	39,378			
	Totals:	34,780	50,922			
7	Ripon City	10,050	1,812	N. V. Hepple	High Skellgate, Ripon	Ripon 382
	Ripon and Pateley Bridge R.	14,930	124,861			
	Totals:	24,980	126,673			
8	Harrogate B.	51,930	8,320	D. D. Payne	Municipal Offices, Harrogate	Harrogate 5031
	Knaresborough U.	8,530	2,494			
	Nidderdale R.	15,860	75,009			
	Totals:	76,320	85,823			
9	Tadcaster R.	28,110	75,833	R. G. Smithson	Wetherby House, Wetherby	Wetherby 438
	Wetherby R.	22,050	64,424			
	Totals:	50,160	140,257			
10	Goole B.	19,340	1,267	S. K. Appleton	6/7 Belgravia, Goole	Goole 936/7
	Selby U.	10,200	3,848			
	Goole R.	9,160	36,776			
	Selby R.	6,560	32,909			
	Totals:	45,260	74,800			

Div. No.	County Districts	Population (Estimated Mid 1956)	Acreage	Divisional Medical Officer	Address of Divisional Health Office	Telephone Number
11	Castleford B.	41,740	4,394	J. M. Paterson	"Castledene", Pontefract Road, Castleford	Castleford 2689
	Normanton U.	18,560	3,066			
	Totals:	60,300	7,460			
12	Pontefract B.	24,540	4,865	J. F. Fraser	Baghill House, Walkergate, Pontefract	Pontefract 3291
	Featherstone U.	14,340	4,424			
	Knottingley U.	10,730	2,835			
	Osgoldcross R.	7,800	33,954			
	Totals:	57,410	46,078			
13	Morley B.	39,520	9,493	F. G. E. Hill	Health Dept., Town Hall, Morley	Morley 4281 2
	Ossett B.	14,490	3,333			
	Horbury U.	8,240	1,280			
	Wakefield R.	19,420	21,335			
	Totals:	81,670	35,441			
15	Batley B.	39,850	4,461	J. F. Caithness	Medical Officer's Dept., Market Place, Batley	Batley 666
	Heckmondwike U.	8,590	696			
	Totals:	48,440	5,157			
16	Garforth U.	13,320	4,020	A. L. Taylor	Oulton Lane, Rothwell	Rothwell 2326/7
	Rothwell U.	24,740	10,698			
	Stanley U.	16,710	4,866			
	Totals:	54,680	19,584			
17	Spenborough B.	36,690	8,251	W. M. Douglas	Elm Bank, Bradford Road, Cleckheaton	Cleckheaton 844
	Mirfield U.	11,810	3,394			
	Totals:	48,500	11,645			
18	Brighouse B.	30,490	7,873	F. Appleton	Mill House, Huddersfield Road, Brighouse	Brighouse 796
	Elland U.	18,890	2,795			
	Queensbury and Shelf U.	8,920	5,946			
	Totals:	58,300	16,614			
19	Todmorden B.	18,300	12,789	J. Lyons	Abraham Ormerod Medical Centre, Todmorden	Todmorden 382
	Hebden Royd U.	9,870	7,084			
	Ripponden U.	5,140	13,289			
	Sowerby Bridge U.	18,260	5,763			
	Hepton R.	4,030	21,758			
	Totals:	55,600	60,683			
20	Colne Valley U.	21,460	16,054	E. Ward	Woodville, Scar Lane, Golcar	Milnsbridge 933/4
	Denby Dale U.	9,570	10,165			
	Holmfirth U.	18,840	17,648			
	Kirkburton U.	17,540	13,847			
	Meltham U.	5,140	5,906			
	Saddleworth U.	16,580	18,485			
	Totals:	89,130	82,105			

Div. No.	County Districts	Population (Estimated Mid 1956)	Acreage	Divisional Medical Officer	Address of Divisional Health Office	Telephone Number
22	Hoyland Nether U.	15,780	1,998	J. M. Russell	Mortomley Hall, High Green	High Green 292
	Penistone U.	6,590	5,593			
	Stocksbridge U.	10,320	4,630			
	Penistone R.	7,320	29,003			
	Wortley R.	46,480	48,698			
	Totals:	86,490	89,922			
23	Hemsworth U.	13,890	4,163	J. S. Walters	Adiscombe House, Barnsley Road, Hemsworth	Hemsworth 77/8
	Hemsworth R.	50,770	29,019			
	Totals:	64,660	33,182			
25	Cudworth U.	8,790	1,746	R. Barnes	6 Victoria Road, Barnsley	Barnsley 2247/8
	Darfield U.	6,460	2,018			
	Darton U	14,540	4,725			
	Dodworth U.	4,170	1,857			
	Royston U.	8,180	1,423			
	Wombwell U.	19,000	3,838			
	Worsbrough U.	14,440	3,420			
	Totals:	75,580	19,027			
26	Rawmarsh U.	19,600	2,602	D. J. Cusiter	Dunford House, Wath upon Dearne	Wath 2251/2
	Swinton U.	12,400	1,718			
	Wath upon Dearne U.	14,090	2,677			
	Totals:	46,090	6,997			
27	Adwick le Street U.	18,550	3,605	J. Ferguson	Council Offices, Adwick le Street	Adwick le Street 2176
	Bentley with Arksey U.	21,630	4,950			
	Totals:	40,180	8,555			
28	Tickhill U.	2,580	5,580	A. Penman	County Council Divisional Offices, Station Road, Doncaster	Doncaster 61571
	Doncaster R.	56,680	75,092			
	Totals:	69,260	80,672			
29	Thorne R.	33,770	38,419	G. Higgins	Council Offices, P.O. Box 4, Thorne	Thorne 3130
30	Conisbrough U.	17,400	1,593	J. A. W. Reid	Council Offices, Adwick Road, Mexborough	Mexborough 3011
	Dearne U.	26,860	3,888			
	Mexborough U.	18,710	1,452			
	Totals:	62,970	6,933			
31	Maltby U.	13,830	4,788	J. M. Watt	"Edenthorpe", Grove Road, Rotherham	Rotherham 3131/2
	Kiveton Park R.	18,550	20,070			
	Rotherham R.	54,100	28,734			
	Totals:	86,480	53,592			

PART IV

NATIONAL HEALTH SERVICE ACTS

HEALTH CENTRES

" 21.—(1) It shall be the duty of every local health authority to provide, equip and maintain to the satisfaction of the Minister, premises which shall be called ' Health Centres ' at which facilities shall be available for all or any of the following purposes:—(a) general medical services; (b) general dental services; (c) pharmaceutical services; (d) services which the local health authority are required or empowered to provide; (e) hospital out-patient services; (f) health education."

To a large extent the reasons of building stringency and the need for research before new developments are made still hold to-day as they did in 1948 when the Minister deferred the requirement of the County Council submitting schemes under this section for approval until a later date to be specified by him.

The building of a health centre at present is likely to be justified only where a largely new population needs to be provided with health service, e.g. in a new town, large housing estates or extensive re-development areas.

CARE OF MOTHERS AND YOUNG CHILDREN

" 22.—(1) It shall be the duty of every local health authority to make arrangements for the care, including in particular dental care, of expectant and nursing mothers and of children who have not attained the age of five years and are not attending primary schools maintained by a local education authority."

Ante- and Post-natal Services

In May, the Ministry of Health issued Circular 9/56 to Chairmen of Boards of Governors and of Hospital Management Committees for hospital groups having a substantial number of maternity beds, asking them to arrange for the holding of meetings of professional representatives from the three parts of the National Health Service involved, i.e. the hospital specialist service, the local health authority services and the general practitioners. The object of these meetings was the free discussion by the professional representatives of a Memorandum on ante-natal care related to toxaemia of pregnancy, embodying advice from the Standing Maternity and Midwifery Advisory Committee and endorsed by the Central Health Services Council.

What was in mind was that the medical issues raised by the memorandum should, in the first instance, be fully discussed and reports submitted to the respective administrative bodies on conclusions which may have been reached which had administrative implications, so that consideration could be given to any action which may have been needed to effect them. That such meetings were deemed necessary were the the conclusions of an enquiry into the cause of maternal deaths which made it clear that the principal cause of avoidable maternal death in this country was that of toxaemia of pregnancy.

It was suggested by the Ministry that the agenda for the meetings should include the following points:—

1. Any points for discussion on the actual content of the Memorandum.
2. The part to be played by hospital ante-natal clinics, general practitioners, midwives and local health authority ante-natal clinics in the ante-natal care of:—
   (a) The patient booked for admission to hospital under a consultant obstetrician.
   (b) The patient booked for admission to a general practitioner hospital unit.
   (c) The patient booked for home confinement under maternity medical services.
   (d) The patient booked for home confinement by a midwife.
3. Any local arrangements needed to ensure a follow-up home visit of a patient who fails to attend for an ante-natal examination on the day appointed.
4. Arrangements for hospital treatment of early toxaemia.
5. Any necessary arrangements for blood tests during the ante-natal period.
6. Interchange of records.
7. Health Education.

Dr. J. M. Anderson, Senior Medical Officer for Care of Mothers, Young Children and Nursing Services, was deputed to attend all the meetings so that continuity of County policy was maintained.

In the southern part of the County within the administrative area of the Sheffield Regional Hospital Board, meetings at Hospital Management Committee level were held at Barnsley (2), Doncaster, Rotherham and Sheffield (2) and were completed by the 16th October. These meetings were purely connected with the preventive and curative aspects of toxaemia and were in no way associated with the investigations being undertaken by the Cranbrook Committee which was set up to enquire into the administrative aspect of the maternity services generally.

In the northern part of the County within the administrative area of the Leeds Regional Hospital Board, Hospital Management Committee areas have been grouped, apparently with the object of reducing the number of meetings and the saving of time; however, at the end of the year, there were still outstanding the meetings of the Bradford, Bingley, Keighley, Skipton and Settle Management Committees, the Leeds, Ilkley and Otley Management Committees, and the Halifax and Huddersfield Management Committees.

The following is a summary of the conclusions which were reached at the meetings under the respective headings of the agenda:—

1. The Memorandum was worthy of circulation to every general practitioner and steps should be taken to ensure this being done.

   There was generally an inadequacy of ante-natal beds, which at present bear no relation to population requirements or to the number of existing lying-in beds.

2. (a) In cases of abnormality, the patients should attend the hospital clinics throughout the pregnancy. Where a case is potentially normal, the patient should be referred back to her own practitioner or the local health authority clinic for ante-natal care up to the thirty-sixth week.

   (b) Bookings for admission should only be made on the recommendation of the general practitioner. In one area, the consultants considered that the practitioner hospital unit was not suitable for the treatment of toxaemia on account of the fact that there was not any resident medical staff or specially trained nursing staff and facilities available for the proper care of premature babies, and immediate replacement transfusion when required.

   (c) At one meeting, it was thought that in order to obtain a more efficient general practitioner obstetric service, the conditions for entry to the ' obstetric list ' should be standardised throughout the country. The general opinion, however, was that the ' obstetric list ' should be abolished, for if a six-month appointment in a maternity unit was one of the qualifications of entry to such a ' list,' many more ' house ' appointments in obstetrics would be necessary in the maternity hospitals in the area.

   It was the view of most committees that the minimum number of two ante-natal examinations required to be carried out by a general practitioner under the regulations governing the maternity medical services was inadequate.

   Co-operation between general practitioners and midwives at ante-natal clinics was advisable; the midwife should be allowed to attend properly constituted clinic sessions in practitioners' surgeries.

   (d) This particular item provided much discussion in the various committees. It was considered that the patient should also book the doctor; however, it was suggested that it was the right of the patient to choose whether or not she wanted to engage a doctor. The midwife would always be required to summon one in the event of any abnormality of the mother and child occurring during pregnancy, labour or lying-in. It was the general view, that the midwife should stress to the patient the importance of being seen either by her own doctor or a doctor of her choice from the ' obstetric list'. Local health authority representatives drew attention to the fact that midwives in their employ are required to induce the patient to be seen by the clinic doctor if the private practitioner is not booked.

3. There appeared to be adequate arrangements in force to cope with the follow-up of absentees from ante-natal clinic sessions. One committee, however, resolved that where a patient failed to attend the hospital clinic, the general practitioner should be notified of her non-attendance and a letter be sent by the hospital inviting her to a subsequent session. In the meantime, the practitioner should ensure that the patient is visited by either himself or the health visitor.

4. It was the general view that existing arrangements for the hospital treatment of early toxaemia were inadequate due to the shortage of beds although it was pointed out that, in some areas, normal patients were being unnecessarily admitted to hospital for confinement and using beds which could well be utilised by ante-natal cases. One committee thought that all cases of toxaemia, excepting the mildest, should be admitted to hospital, the end result of which might well be the abolition of emergency admissions.

5. Liaison with the pathological and blood transfusion services in the various areas was excellent, but the utilisation of such services could be improved upon. It was necessary for blood tests to be undertaken during each pregnancy. Where practitioners did not take blood samples, facilities were available for this to be done on their behalf at hospitals and local health authority clinics. Routine haemoglobin estimation must be done early in pregnancy and again at the thirty-second week.

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6. There was unanimity of opinion that some standardisation of ante-natal record cards between the three administrative bodies responsible for the midwifery service was necessary to improve its efficiency.

7. The value of the local health authority clinic in the preparation for motherhood was accepted, particularly from the hospitals where large attendances at ante-natal clinic sessions did not allow time to be devoted to health education in relation to the prevention of toxaemia by advice in dietary, regular weighings, blood pressure estimations, urine examinations.

Ante- and Post-natal Clinics.—There were five ante-natal clinics discontinued and a new one established at Kirkburton, so that on the 31st December, there were 148 clinics in operation at which 61,789 attendances were made, an increase in attendances of 1,586 over the previous year. Many more women are now booking a doctor for home confinement whereby he accepts responsibility for their ante-natal care; for this reason, it might be expected that attendances at local health authority clinics would fall even further than has been the practice since the 'appointed day'. However, there has been a growing realisation among practitioners of the benefits which can be obtained by patients from their attendance at clinics for health education, whilst they apply themselves to the clinical care. The hospitals are also using the clinics for similar purposes in respect of patients booked for institutional confinement. In some areas, practitioners are utilising the authority's clinic premises in which to conduct their own ante-natal sessions, and speak highly of the benefits of such an arrangement, for nursing staff is available and the doctor is absolved from the clerical work involved in the keeping of adequate records and the despatching of blood specimens. Other practitioners ask for the attendance of the midwife for properly constituted ante-natal clinic sessions within their own premises.

Relaxation classes have become very popular. Whilst their use, other than from a psychological point of view, is doubtful the teaching of the patient, so that she acquires the necessary understanding of what she has to expect, must make her less apprehensive and probably more co-operative during labour. The following is an extract from a letter from a patient which was sent to the department.

"I had my first baby nine weeks ago and I want to say how much I appreciate the help and guidance which I have had and, needless to say, will still need to have. I attended relaxation classes and these helped enormously in giving me an easier labour and also having knowledge of what to expect. I did not have the fear of the unknown, and this I found was so important. I felt I wanted to write a 'thank you' to someone for all this. We mothers and babies to-day are most fortunate and I for one appreciate this fact very much."

It is estimated that at least 2,000 cases of domiciliary confinement were not medically examined after childbirth and the need for improvement in the educational methods directed towards post-natal care is apparent. The post-natal facilities of the local health authority have never attained the popularity of that obtained during the ante-natal period; however, on the assumption that 72 per cent. of the domiciliary confinements in the County were provided with maternity medical services by general practitioners, the incidence of maternal morbidity should be on the decrease.

Dental Treatment of Expectant and Nursing Mothers and Pre-School Children

For the purpose of discharging its responsibility for the dental care of the expectant and nursing mother and the pre-school child, the authority makes use of the County Dental Service. Inspection and treatment is undertaken by dental officers, whole-time or part-time, employed in that service in clinic premises which are often within the curtilage of premises used also for infant welfare purposes. Where dental officers or clinics are not available, arrangements may be made to refer the expectant or nursing mother to the care of a private dental practitioner.

The Chief Dental Officer reports:—

"In my opening remarks to the Report on the School Dental Service, I have referred to the ever-increasing demands of the maternity and child welfare services. In some of the clinics in South Yorkshire, the dental treatment of expectant and nursing mothers is occupying nearly half the dental officers' time. The figures have this year reached a new high level. Since the introduction of the National Health Service, the number of expectant and nursing mothers treated by County dental officers has increased from 58 in 1948 to 1,428 in the year under review.

The following table indicates the work which has been carried out during the year for expectant and nursing mothers by our own dental officers and private practitioners under the County Scheme:—

	County Dental Officers	Private Practitioners	Total
No. of cases referred	2,156	1,304	3,460
No. of cases examined	1,691	958	2,649
No. found to require treatment	1,572	952	2,524
No. treated	1,428	846	2,274
No. made dentally fit	1,269	765	2,034
No. of extractions	12,001	8,608	20,609
No. of fillings	1,409	1,049	2,458
No. of general anaesthetics	1,337	510	1,847
No. of scalings	378	344	722
No. of complete dentures	1,160	583	1,743
No. of partial dentures	444	286	730
No. of X-rays	38	34	72
No. of crowns	3	2	5
No. of inlays	—	—	—
No. of root treatments	6	—	6

In addition to the above, 75 cases made 145 attendances for treatment by dental hygienists.

The following work has been carried out during the year for pre-school children by school dental officers:—

No. inspected	1,434	No. of teeth filled	283
No. treated	1,388	No. of fillings	303
No. of attendances	1,670	No. of teeth treated with silver nitrate	67
No. of extractions	3,010	No. of dressings	26
No. of general anaesthetics	1,013	No. of scalings	1"

Infant Welfare

On the 31st December, 1955, there were 225 child welfare centres operating within the Administrative County; two of these were discontinued during the year, namely, Bardsey and Hirst Courtney, but with the delivery of the mobile clinic to serve the rural districts of the County in South Yorkshire, there were 224 centres operating at the end of the year.

A total of 46,111 infants under the age of five years attended welfare centres, and of these, 21,165 under the age of one year made a first attendance, this figure representing 80 per cent. of the age group. There was an increase in attendance over the previous year by infants under the age of 1 year of 16,116.

Dr. C. C. Harvey, County Paediatrician, reports:—

" For whom no bell tolls. Stillbirths may soon outnumber infant deaths, and would repay much more intensive study, both by doctors and midwives. Too easily, they are written off without thought for the future. Miscarriages in particular are so soon dismissed from our thoughts, yet nevertheless a bright home prospect has often been dashed and possibly a mother has sustained lifelong discouragement. Much could be learned by regularly obtaining post-mortem examination of stillbirths, and collating the findings.

Inhalation of Vomit. I judge from observation that midwives and hospital nurses are not emphatic enough in their own practice, or in teaching mothers about the importance of laying babies down strictly on their sides after feeds. All too often, babies are allowed to wriggle into the supine position at an early age.

Umbilical Hernia. Much effort is still being expended in applying patches of plaster or rubber baubles to all sizes of umbilical herniae in young babies. None of these trifles effect any control by holding a hernia reduced in such a way as to promote closure of the ring. A careful study published this year by J. C. Haworth at Sheffield Children's Hospital confirms that all small herniae closed spontaneously, with no need of any external applications. However, in a controlled series of larger herniae (protruding more than ½ inch), it was found that the cure rate was greatly increased by several weeks of continuous retention with specially applied tight strapping, which caused folds of skin to overlap tightly over the umbilicus. Any sort of strapping less elaborate than this is not worth applying. It is only needed for the large herniae. (Brit. Med. J. 1956, II 1286).

Immunisation. This year, I have been impressed with the numbers of babies whose programme of immunisation has been deferred on trivial grounds. The story usually is that baby kept on having colds or showing chest signs. Nearly all of these babies are subjects of respiratory allergy and not infection, and I would think they are the very ones who need early protection against whooping cough, despite the clinical signs.

Combined prophylactic immunisation. There is much publicity for a very few cases of encephalopathy or poliomyelitis which are deemed to follow upon combined prophylaxis; but no one has calculated how many children, in the meantime, have died of whooping cough pneumonia, unprotected, because parents have been discouraged by the numerous injections of the official programme. We might well find that far fewer children would die on a combined immunisation programme which secures a wider measure of popularity. At present, pertussis is the more important killing disease.

The combination of tetanus prophylaxis in the programme now appears increasingly desirable. It requires to be shown that adequate antibody production against tetanus can be attained at the same age and dosage intervals as for diphtheria and pertussis. When tetanus prophylaxis is widespread, it would be possible to revise the British hospital casualty practice in line with that of the Canadian and American Armed Forces, in giving booster toxoid instead of horse serum anti-toxin for the wound prophylaxis. It may be argued that there is more risk of anaphylaxis from horse serum on the one hand, than there would be from tetanus through a rare delayed response to booster toxoid on the other."

Welfare Foods

The distribution of Welfare Foods is carried out from Divisional Health Offices, Child Welfare Centres, and to a lesser extent, from private households and through the retail trade. The following table shows the over-all distribution during the year.

	National Dried Milk (tins)	Cod Liver Oil (bottles)	Vitamin A and D Tablets (packets)	Orange Juice (bottles)
Issued to beneficiaries against coupons	492,923	151,185	65,009	871,805
Issued to hospitals and day nurseries	1,182	591	—	3,566
Total Issues	494,105	151,776	65,009	875,371

In my last Report I referred to the falling off in consumption of Welfare Foods, and the following table of the distribution during each quarter of 1956 shows that consumption of National Dried Milk continues to decrease, but with an upward trend during the period July to September, as in 1955.

For comparative purposes the figures relating to the corresponding periods in 1955 are shown in parentheses.

	National Dried Milk (tins)	Cod Liver Oil (bottles)	Vitamin A & D Tablets (packets)	Orange Juice (bottles)
January to March	123,476	41,547	16,162	195,074
	(133,213)	(43,028)	(13,952)	(169,973)
April to June ..	122,734	34,480	16,961	241,563
	(128,088)	(35,635)	(14,534)	(194,802)
July to September	126,169	32,896	16,048	232,252
	(130,129)	(36,701)	(15,738)	(256,773)
October to December	121,726	42,853	15,838	206,482
	(126,958)	(46,192)	(15,356)	(196,366)
Totals ..	494,105	151,776	65,009	875,371
	(518,388)	(161,556)	(59,580)	(817,914)

Illegitimate Children

There were 1,002 illegitimate births which is approximately one in 27 of the total births. The rates in respect of neo-natal deaths, infant deaths and stillbirths among illegitimate births are constantly higher than those of births in wedlock. The stillbirth rates for the year were 23 for legitimate births and 27 in respect of the illegitimate.

This problem is one, the solution of which is closely connected with education and it should be directed chiefly to the young. So far as the general care of the unmarried expectant mother is concerned, it should be given with understanding and sympathy for there is little doubt that without these, the mother's capacity for maternal feeling will be inhibited, with possible disturbances in the psychical life of the infant.

There were 699 cases dealt with through the Health Department, of which 42 were non-county cases. The following table indicates the manner in which the cases were settled and it is notable that in 69 per cent. of them, the mother retained the child.

Number of cases dealt with during the year:

Referred by Moral Welfare Organisations	88
Ascertained by staff of the Health Department	496
Referred by other services	115
Total ..	699

Analysis of cases:

Married	with previous illegitimate children	86
	without previous illegitimate children	99
Unmarried	with previous illegitimate children	120
	without previous illegitimate children	370
Widowed	with previous illegitimate children	9
	without previous illegitimate children	15
	Total ..	699

Ages:

Under 20 years of age	161
20-25 years of age	233
26-30 years of age	135
31-40 years of age	148
Over 40 years of age	22
Total	699

Disposal:

Cases settled	Marriage	38
	Baby died	28
	Grandparents taking baby	29
	Baby adopted	67
	Baby fostered	17
	Mother keeping baby	480
Cases referred elsewhere		18
Cases not finally settled		22
Total		699

Accommodation was provided for 124 cases in moral welfare homes as outlined below:—

	Ante- and Post-natal	Ante-natal only	Post-natal only	Governing Body
Bradford—Oakwell House	3	—	1	Bradford County Borough
Bradford—St. Monica's	18	2	—	Church of England
Bramley—Mount Cross	6	—	—	Salvation Army
Darlington—St. Agnes'	1	—	—	Church of England
Halifax—St. Margaret's	14	—	1	Church of England
Harrogate—St. Monica's	5	—	—	Church of England
Huddersfield—St. Katherine's	8	—	—	Church of England
Hull—Sutton House	1	—	—	Church of England
Lancaster—Queen St. Hostel	1	—	—	Church of England
Leeds—Browning House	14	2	1	Voluntary Committee
Leeds—St. Margaret's	8	—	—	Roman Catholic Church
Leeds—Wyther Hostel	1	—	—	Leeds County Borough
Lincoln—Quarry Maternity Home	1	—	—	Church of England
Liverpool—St. Monica's	1	—	—	Church of England
Mansfield—Grosvenor House	1	—	—	Church of England
Parkstone—St. Monica's	1	—	—	Church of England
Pontefract—The Haven	12	—	—	Church of England
Salford—Manchester and Salford District Maternity Home	1	—	—	Church of England
Sheffield—St. Agatha's	19	—	—	Church of England
Wilpshire—The Grange	1	—	—	Church of England
	117	4	3	

Premature Infants

Prematurity, as defined by international agreement, is based on a birth weight of 5½ lb. or less, and in accordance with this definition there were 1,825 live births. It will be noted from the table below that 300 of these infants died within 28 days, and that 283 of them did not survive seven days. Of the deaths in the first day of life, at least 60 per cent. of them were of a birth weight which would indicate clinical manifestations of prematurity. The influence of prematurity upon infant mortality presents one of the outstanding problems of the day and unfortunately is one which is not generally appreciated: it was directly or indirectly responsible for more deaths than those from all forms of tuberculosis.

The work undertaken by the nursing staff continues to contribute to the maintenance of a high survival rate among those infants in the higher weight groups nursed in their own homes.

The Fate of Premature Babies born in the Year 1956, to Mothers normally residing in the West Riding Administrative County Area wherever the Birth took place

Total adjusted live births—26,468

Number of live premature births—1,825
Number born dead—314

Percentage of premature live births to total live births—6·9

Weight Group lb.	Number of Premature Births						Number Dying (Days of Survival)														Number surviving over 28 days					Percentage Survival 1956	Percentage survival in previous years				
	Born Alive					Born Dead	First Week							Second Week							Over 14 up to 28 days										
	A	B1	B2	C	Total		1	2	3	4	5	6	7	8	9	10	11	12	13	14		A	B1	B2	C	Total		1955	1954	1953	1952	1951
5—5½	203	12	216	294	725	33	4	8	6	3	—	1	1	—	—	—	3	1	1	—	—	194	11	212	280	697	96·1	97·4	96·7	94·8	94·9	95·5
4½—5	134	6	112	183	435	44	14	7	5	3	3	1	1	1	—	—	—	—	—	—	1	124	5	105	165	399	91·7	91·5	93·5	94·3	93·9	92·2
4—4½	57	7	67	104	235	35	13	6	3	—	—	1	—	—	—	—	—	1	—	—	1	54	6	58	92	210	89·4	90·3	87·6	88·5	87·4	84·7
3½—4	39	1	32	75	147	43	24	7	2	1	2	—	—	—	1	—	—	—	—	—	—	33	1	26	50	110	74·8	76·5	80·2	80·4	77·4	72·1
3—3½	17	1	29	56	103	38	18	6	2	1	2	—	2	—	—	—	1	—	—	—	1	12	—	23	35	70	68·0	66·3	62·6	61·4	67·1	58·4
2½—3	15	—	16	36	67	42	22	5	2	1	2	2	1	1	—	1	—	1	—	—	—	8	—	9	12	29	43·3	45·8	36·7	52·4	40·6	34·8
2—2½	10	—	6	31	47	38	28	4	2	1	—	1	1	—	—	1	—	—	—	—	—	2	—	1	6	9	19·1	29·3	21·2	15·8	7·3	14·7
1½—2	10	—	5	25	40	32	28	5	2	—	1	1	1	—	—	—	—	—	—	—	1	—	—	1	—	1	2·5	4·2	7·5	12·9	6·1	2·8
1½ and under	8	—	1	17	26	9	26	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3·7	—
Total	493	27	484	821	1825	314	177	48	24	10	10	7	7	2	1	2	4	3	1	—	4	427	23	435	640	1525	83·6	85·9	84·6	83·7	82·6	82·7

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300

A —Born in Domiciliary Practice
B1—Born in Private Nursing Home
B2—Born in Maternity Home
C —Born in General Hospital

The weight groups in the first column of this table should be read as under:—

"5—5½ lb." means "Over 5 lb. up to and including 5½ lb."
"4½—5 lb." means "Over 4½ lb. up to and including 5 lb."
The remaining weight groups should be read in the same way.

FOLLOW-UP OF PREMATURE BABIES BORN IN 1949 TO MOTHERS NORMALLY RESIDENT IN THE WEST RIDING ADMINISTRATIVE COUNTY AREA

Total born	1,426
Number who have removed outside Administrative County or where parents refuse to co-operate in the enquiry	240
	1,186

Weight Group lb.	Period of Survival Number dying at following periods of life					Survived over 7 years
	Under 1 Year	1 year and under 2 years	2 years and under 3 years	3 years and under 4 years	4 years and under 7 years	
5—5½	44	2	2	1	—	437
4½—5	33	2	—	1	—	227
4—4½	36	2	—	—	—	133
3½—4	38	—	—	—	—	66
3—3½	25	—	—	—	—	34
2½—3	34	—	—	—	—	12
2—2½	30	—	—	—	—	5
1½—2	15	—	—	—	—	—
1½ and under	7	—	—	—	—	—
Total	262	6	2	2	—	914
Percentage Survival	77·9	77·4	77·2	77·1	77·1	77·1

The weight groups in the first column of the table should be read as under:—
"5—5½ lb." means "Over 5 lb. up to and including 5½ lb."
"4½—5 lb." means "Over 4½ lb. up to and including 5 lb."
and so on.

Children neglected or ill-treated in their own homes

The Joint Circular of the Ministries of Education and Health and Home Office dated the 31st July, 1950, called for the more effective co-ordination of the resources of local authorities and voluntary organisations in the prevention of neglect or ill-treatment of children in their own homes. The action which was taken in the Administrative County to implement the recommendations was that of designating each Divisional Medical Officer as co-ordinating officer. He is the responsible officer for the local administration of those county services which have far-reaching effects on the health and welfare of all children, and is also Medical Officer of Health for the county districts within the division, thereby having the closest contact with the housing committees, a factor of importance in dealing with the break-up of families. Co-ordinating Committees were set up with power to co-opt persons either as full members or for individual meetings according to special circumstances prevailing in the division. During the first year, Co-ordinating Committees held regular meetings each quarter; thereafter, the frequency of meetings differed according to the varying circumstances in the divisions.

The great value of these Co-ordinating Committees has been the passing of information as between local authority and voluntary organisations, thus avoiding duplication of service and enabling a combined effort to be made in respect of any particular family. However, it is not always possible to avoid duplication of visits, for visitors may have particular functions which they alone can discharge, and which do not necessarily overlap; it may be necessary, as an example, for a health visitor, a probation officer, an officer of the National Assistance Board to be visiting the same family; the fact that these officers are aware, through the Co-ordinating Committee, of what action has been decided upon is of extreme importance.

The widest use of the domiciliary services of the authority has been applied in the prevention of neglect and ill-treatment although a hard core of problem families still remains resistant to the efforts made to improve their lot, and it is the children of such families which give rise to the greatest concern. Intensive health visiting has been undertaken, many of the visits being made in hours generally regarded as constituting off-duty time. Such work has not been entirely devoted to the giving of advice, for

teaching by demonstration within the home by the health visitor, in conjunction with a home help, has often produced fruitful results. It is frequently found that however intensive the efforts of the health visitor may be in giving advice on such matters as the cleanliness of the home, budgeting, rent, hire purchase, her only influence is upon the mother and children, the father being unco-operative, and in instances where he controls the purse strings, such advice appears to be of negative value. In respect of problem families, housing still looms as a major issue and efforts to resolve intolerable home conditions by rehousing are often negatived by subsequent eviction. Generally speaking, however, the number of evictions has decreased over the past five years due to the co-ordinated effort of the special Committees in obtaining a stay of execution of eviction notices. This has led, in some cases, to satisfactory arrangements being made regarding payment of arrears under the supervision of the health visitor, and ultimate progress towards rehabilitation.

The number of children in the care of the local authority is frequently confusing and should not be regarded as a true indication of a rise or fall in the number of children neglected; many of them are deprived of parental care temporarily. In 1955, there were 168 cases of parental admission to hospital necessitating the admission into residential care of 407 children; of these, 85 were confinement cases involving 204 children and 83 cases of illness accounting for 203 children. All of these admissions for the temporary care of the children were investigated by the Divisional Medical Officer in consultation with the Children's Officer, and were found to present problems which neither the employment of foster parents nor home help would meet.

Prevention of Break-up of Families

In November, 1954, the Ministry of Health issued to all Local Health Authorities Circular 27/54 emphasising the Minister's concern at the bad effects on the health, especially the mental health, of children which often follow the break-up of the family. It was desired that the Local Health Authorities, making use of their existing powers augmented where necessary by any additional proposals, should do everything possible to prevent such a situation arising. After careful consideration, the recommendations were remitted to the Co-ordinating Committees already established for the prevention of neglect or ill-treatment of children in their own homes, which fuse the combined efforts of all statutory and voluntary social agencies concerned with the care of children. In the following year, the British Medical Association forwarded copies of the Circular to all Local Medical Committees and, in advising Medical Officers of Health of this distribution, drew attention to the contribution which could be made to the problem by general practitioners. At a meeting of the Standing Sub-Committee on Co-operation between General Practitioners and Medical Officers of the West Riding County Council held on 6th October, 1955, it was agreed:

(a) That it is inadvisable that one family doctor should represent other doctors at the meetings of the Committee on correlation of information about children neglected or ill-treated in their own homes.

(b) That the family doctor will be notified, when there is a medical aspect, of any case which is to be the subject of consideration by the Committee.

(c) That in certain cases, where medical action is involved, the family doctor will be invited to attend the Committee. If he is unable to, or does not consider it necessary to attend, he will be informed of the action taken.

With this final agreement giving added impetus to the work of the Co-ordinating Committee, there has been satisfying evidence of a lesser incidence of preventable break-up of family life. Reference in detail is to be found under the preceding heading, where the work is often to the same end, under Health Visiting and under Home Helps. Of interest has been the recourse made in the Wortley (No. 22) Division to the Sheffield Family Service Unit. In reference to a particularly difficult case where the Family Service Unit has been of invaluable help, the Divisional Medical Officer writes:—

"The family has been under our supervision for many years, and the Family Service Unit are the only people who have been able to do anything positive other than what we have done through the Health Visitor, and what the St. John Ambulance Brigade Nursing personnel have done in the way of helping in the home and escorting the children to Hospital. The Unit has done a tremendous amount of work for this family—found clothing, found and laid linoleum, decorated, stayed with the family for most of the day and attempted to educate in housekeeping, done the shopping, and in short have kept the family going in this line for many months."

Leukaemia in Childhood

Early in the year, we were invited to take part in an environmental survey, sponsored by the Medical Research Council, into leukaemia in childhood. Statistics had shown that over the past twenty-five years, the mortality from leukaemia in the country had been almost trebled; furthermore, that there had been a sharp rise in the risk of death from this condition between the ages of one and three years.

The field work associated with the survey involved the interviewing of the parents of all children under the age of ten years who had died in the years 1953, 1954 and 1955 from leukaemia or other form of malignant disease. In this respect, the number of deaths to be investigated in the Administrative County were 34 from leukaemia and 25 from malignant disease. It was also necessary to interview the

parents of a similar number of control children matched to those of the survey children in respect of age, sex and place of birth. Each interview consisted of the collection of as many facts as the parents could remember about the life and habits of the dead and control children, including exposure to X-rays and other radio-active materials, e.g. luminous watches and paint, detergents, aerosols, 'sophisticated' foods. One of the ideas which had prompted the survey was that exposure to X-rays may predispose to malignant changes in certain tissues. This called for a detailed history of all types of X-ray exposure before the onset of the fatal illness and information in respect of the mothers of both groups of all exposures before the birth of the child. To obtain the closest possible uniformity in the recording of information, the work was delegated to the two Senior Medical Officers on the Headquarters Staff.

A preliminary report on the examination of approximately one-third of the histories of the children in the survey throughout the country, which were available later in the year, revealed that only in one respect was there marked dissimilarity between the victims of malignancy and the controls; this was in respect of the number of mothers who had undergone pelvic exposure to X-ray whilst the child was in utero. The figures were 85 in survey cases against 45 in the controls. There was a similar disparity in cases of leukaemia, namely 42 survey children against 24 controls, and also for other forms of malignancy 43 against 21 controls.

Whilst at this stage of the investigation the preliminary report cannot be accepted as conclusive evidence of the need for caution in the use of X-rays for diagnostic purposes, the promulgation of the findings of the complete enquiry are awaited with feelings of apprehension.

Day Nurseries

At the end of the year, six nurseries were in operation making provision for 260 children. On the 31st July, the Sowerby Bridge nursery, providing accommodation for 50 children, was closed on account of the small number of attendances being made. Financial responsibility was accepted for the accommodation of nine children in nurseries administered by the County Boroughs of Doncaster, Leeds, Sheffield and Wakefield, and six were still in attendance at these nurseries on the 31st December.

It is the policy of the County Council to admit children into nurseries on the grounds of health needs only, the interpretation of which is fairly wide. However, there is still some demand for nursery accommodation as is indicated in another section of the report by the registration of a private nursery in Keighley.

The authority's nurseries are sited:—

Div. No.	*Day Nursery*	*No. of Places Provided*
3.	Keighley.	50.
4.	Shipley.	50.
8.	Harrogate.	40.
15.	Heckmondwike.	40.
18.	Brighouse.	40.
19.	Todmorden.	40.

MIDWIFERY

> " *23.—(2) It shall be the duty of every local health authority to secure, whether by making arrangements with Boards of Governors of teaching hospitals, Hospital Management Committees or voluntary organisations for the employment by those Boards, Committees or organisations of certified midwives or by themselves employing such midwives, that the number of certified midwives so employed who are available in the authority's area for attendance on women in their homes as midwives, or as maternity nurses during childbirth and from time to time thereafter during a period not less than the lying-in period, is adequate for the needs of the area.*"

The Report of the Committee of Enquiry into the cost of the National Health Service under the chairmanship of C. W. Guillebaud, Esq., C.B.E., was presented to Parliament by the Minister of Health in January. Having outlined the division of responsibility for the provision of the Maternity Services as between the Hospitals, Executive Councils and Local Health Authorities, the Report goes on to state, " Our evidence does, however, indicate that the maternity services are in a state of some confusion, which must impair their usefulness and which should not be allowed to continue. The present structure appears to represent a not very satisfactory compromise between the services which were in existence before the ' Appointed Day', and the new maternity medical service which was introduced with the National Health Service. It seems to us that the time has now come for an appropriate body to review the whole of this field to find out precisely what services, medical and educational, are needed for mothers and young children, and how they can best be provided through the framework of the National Health Service."

This particular matter has been a subject of contention since the inception of the Act and previous reports have referred to it; however, in April, the membership of a Committee to enquire into the maternity services was announced in Parliament under the Chairmanship of the Earl of Cranbrook, C.B.E. The terms of reference of the Committee are " To review the present organisation of the Maternity Services in England and Wales, to consider what should be their content and to make recommendations."

Institutional Midwifery

It has been said that "the expectant mother population has been taught to become hospital minded"; what educational method, other than the provision in certain areas of an abundance of lying-in beds, has been evolved to bring about this supposed change in outlook is not stated. The Royal Colleges advocate hospital accommodation for all births, whilst the Ministry of Health consider that lying-in accommodation for 50 per cent. to 60 per cent. of the total births would meet the need. On the one hand we have idealism, on the other expediency. The resources of the country indicate a realistic approach.

Institutional accommodation was provided for 59 per cent. of the total births during the year, a figure which is completely misleading. The table below indicates that owing to the inequitable distribution of beds, 87 per cent. of the total births in one divisional area were effected in hospital and 35 per cent. in another. In the Doncaster area, with a population of 133,000, provision was made for 40 per cent.

Selection of cases for hospital over the post-war years has been difficult, the shortage of housing accommodation with consequent over-crowding having necessitated the hospitalisation of many potentially normal cases which could, under ordinary circumstances, have remained at home. Although this situation is improving, it is doubtful whether existing beds are being utilised to the fullest advantage; over-booking of beds would appear to take place with frequency, for in areas with a provision of from 70 per cent. to 80 per cent. of the total births, 435 cases were discharged before the tenth day of the lying-in period. Furthermore, if elderly primigravidae and multigravidae of parity four plus are accepted as representing an obstetric risk, they should be booked for hospital automatically; the latest figures available are in respect of the year 1955 when 1,445 cases within these categories were confined in their own homes. Of the 15,975 institutional cases, 4,497 were discharged before the 14th day, of which 1,441 were discharged before the 10th day.

Div. No.	Area	Population	Total Births (Live and Still)	Place of Birth			
				Hospital		Domiciliary	
				No.	%	No.	%
1	Skipton	58,550	845	731	87	114	13
2	Settle	22,790	335	219	65	116	35
3	Keighley	55,540	867	671	77	196	23
4	Shipley	67,220	981	742	76	239	24
5	Horsforth	73,190	1,076	880	81	196	19
6	Otley	34,780	499	401	80	98	20
7	Ripon	24,980	358	266	74	92	26
8	Harrogate	76,320	1,123	914	82	209	18
9	Wetherby	50,160	773	452	59	321	41
10	Goole	45,260	698	313	45	385	55
11	Castleford	60,300	941	554	59	387	41
12	Pontefract	57,410	1,108	557	51	551	49
13	Morley	81,670	1,392	881	64	511	36
15	Batley	48,440	804	644	80	160	20
16	Rothwell	54,680	807	386	48	421	52
17	Spenborough	48,500	709	565	77	144	23
18	Brighouse	58,300	856	606	71	250	29
19	Todmorden	55,600	845	492	59	353	41
20	Colne Valley	89,130	1,195	866	73	329	27
22	Wortley	86,490	1,324	805	61	519	39
23	Hemsworth	64,660	1,440	611	43	829	57
25	Barnsley	75,580	1,350	668	49	682	51
26	Wath upon Dearne	46,090	833	319	39	514	61
27	Adwick le Street	40,180	796	316	40	480	60
28	Doncaster	59,260	1,235	546	44	689	56
29	Thorne	33,770	777	269	35	508	65
30	Mexborough	62,970	1,263	479	38	784	62
31	Rotherham	86,480	1,863	822	44	1,041	56

Domiciliary Midwifery

The domiciliary service makes provision for the booking of a doctor and midwife, but although the doctor may assume responsibility for the case, he need not necessarily be present at the time of the birth of the child. It is imperative, therefore, that a good doctor-midwife relationship exists in order to ensure the success of the service.

There were 11,010 confinements attended by County midwives, and of these, the practitioners contracted to provide maternity medical services for 7,903 cases.

As the Local Supervising Authority under the Midwives Act of 1951, notifications of intention to practise were received from 440 midwives. Of these, 285 were in respect of midwives engaged in domiciliary practice, of which 266 were midwives employed by the County Council; the remaining 155 midwives were practising in hospitals and private maternity homes.

In accordance with the Rules of the Central Midwives Board, midwives are required to summon medical aid in respect of all cases of illness of the patient or infant, or in case of any abnormality becoming apparent in the patient or infant during pregnancy, labour, or the lying-in period. Any further

emergency which may arise also demands of the issue of a medical aid notice. There were 2,970 such notices issued during the year; 607 of them were in respect of midwives employed in maternity homes, and 2,363 from midwives in domiciliary practice. The following table summarises the conditions for which practitioners were summoned:—

PREGNANCY

	Domiciliary	Institutional	Total
Abdominal pain	15	1	16
Abortion—complete	61	—	61
incomplete	5	—	5
threatened	105	—	105
Ante-partum haemorrhage	107	16	123
Breast condition	2	—	2
Disproportion	—	1	1
General condition	35	—	35
Hydramnios	2	—	2
Inter-uterine death	1	—	1
Malpresentation	21	1	22
Multiple pregnancy	2	—	2
Phlebitis	1	—	1
Post-maturity	4	1	5
Pyelitis	2	—	2
Toxaemias —albuminuria	16	3	19
eclampsia	4	—	4
hypertension	33	6	39
oedema	8	—	8
toxaemia	24	6	30
Vomiting	1	—	1
	449	35	484

LABOUR

	Domiciliary	Institutional	Total
Episiotomy	15	17	32
Foetal distress	12	18	30
General condition	16	7	23
Haemorrhoids	1	1	2
Intra-partum haemorrhage	6	2	8
Labour— delayed	175	71	246
notification of	1	—	1
obstructed	2	—	2
precipitate	4	—	4
premature	46	4	50
Laceration—labial	5	20	25
perineal	765	287	1052
vaginal	4	5	9
Malpresentation	75	24	99
Maternal distress	10	—	10
Multiple delivery	13	1	14
Obstetric shock	5	1	6
Prolapsed condition	1	—	1
Retained placenta	52	10	62
Rhesus antibodies	1	—	1
Ruptured membranes	16	1	17
Uterine inertia	23	6	29
Venereal disease	1	—	1
	1,249	475	1,724

LYING-IN

	Domiciliary	Institutional	Total
Abdominal pain	4	—	4
Anaemia	—	1	1
Blood specimen	4	—	4
Breast condition	41	1	42
Chicken pox	1	—	1
General condition	43	5	48
Kidney condition	3	3	6
Maternal distress	—	1	1
Phlebitis	16	3	19
Post-partum haemorrhage	80	17	97
Pyrexia	64	28	92
Refused admission	1	—	1
Subinvolution	3	—	3
Thrombosis	4	—	4
Varicose veins	13	3	16
	277	62	339

CHILD

	Domiciliary	Institutional	Total
Abnormality	24	4	28
Asphyxia	25	6	31
B.B.A.	7	—	7
Cerebral irritation	—	1	1
Chest condition	7	—	7
Congenital defect	5	—	5
Cyanosis	29	6	35
Death	2	—	2
Deformity	15	3	18
Eye condition	72	1	73
General condition	99	4	103
Haemorrhage	4	1	5
Jaundice	10	2	12
Mastitis	2	—	2
Melaena	9	—	9
Prematurity	36	6	42
Skin condition	19	—	19
Stillbirth	14	—	14
Vomiting	9	1	10
	388	35	423

The following statutory notifications were received from midwives during the year.

Maternal death	2
Death of the infant	75
Stillbirth	214
Laying out of the dead	41
Substitution of artificial feeding	1,808
Liability to be a source of infection	148

The County Council, as the Local Supervising Authority under the Midwives Act, is required to exercise supervision of practising midwives within its area. To enable this work to be executed effectively it is delegated to Divisional Medical Officers who are assisted by two non-medical Supervisors. The work undertaken by the Supervisors is summarised as follows:—

Consultations with Divisional Medical Officers	101
Practical visits to midwives	267
General visits to midwives	243
Attendances at labour	8
Attendances at parentcraft classes	40
Visits of inspection at maternity homes	16
Visits undertaken with pupil midwives	19

Post-certificate instruction.—Fifty-seven midwives attended one-week refresher courses; forty-six attended courses arranged by the Royal College of Midwives and eleven those arranged by Local Authorities—Bradford and Hull. In addition to lectures given by obstetricians, teaching methods and the art of teaching are also included. Observation visits to maternity hospitals and group discussion and the study of modern technique form a valuable part of the course.

Four midwives attended a residential four weeks' course to study modern methods in the care of the premature infant at the Sorrento Maternity Hospital, Birmingham, which, under the direction of Dr. Mary Cross, still maintains its position in the country as an authority on the treatment and care of premature infants.

During the year, twelve pupil midwives from the York Maternity Hospital and seven pupil midwives from Nether Edge Hospital, Sheffield, received district training in the County area.

Analgesia.—Gas and air analgesia is available, subject to the midwife being qualified in its administration and the patient having been examined at some time during pregnancy by a medical practitioner who certifies that he has not found any contra-indication to its use. However, should the patient, at some time subsequent to the examination, undergo some form of illness, the midwife must have confirmation from the doctor regarding the validity of the certificate which he issued.

It is usual for the patient to receive instruction in analgesia during the ante-natal period, a time when she is receptive and has not any particular worry, so that when the apparatus is required during labour, she is accustomed to it and able to benefit by obtaining a more efficient state of analgesia.

There were 295 machines in use during the year. The extent to which this service was used is indicated in the following table which shows the percentage take-up in each of the administrative divisions:—

Division No.	Percentage receiving Analgesia				Division No.	Percentage receiving Analgesia			
	Gas and air	Pethidine	Gas and air with Pethidine	Total		Gas and air	Pethidine	Gas and air with Pethidine	Total
1	21	5	43	69	22	33	6	6	45
2	19	6	39	64	23	17	19	37	73
3	21	18	34	73	25	19	9	55	83
4	15	4	74	93	26	12	37	10	59
5	38	4	38	80	27	31	14	27	72
6	32	5	38	75	28	17	23	38	78
7	33	5	55	93	29	19	16	28	63
8	19	10	51	80	30	38	3	44	85
9	45	3	18	66	31	6	37	25	68
10	19	8	55	82					
11	70	2	13	85	Leeds Hospital Region	25	11	44	80
12	10	19	51	80					
13	24	5	55	84	Sheffield Hospital Region	21	19	31	71
15	6	47	16	69					
16	18	19	47	84	W.R. Administrative County	23	15	37	75
17	43	3	35	81					
18	19	3	63	85					
19	27	6	54	87					
20	24	9	47	80					

Flying Squad.—Arrangements are in operation from the undermentioned hospitals whereby emergency units are available for the domiciliary treatment of patients whose condition is too grave to justify immediate transfer to hospital. This service has, over the years, made a valuable contribution towards the reduction of maternal mortality.

St. Helen Hospital, Barnsley.
St. Luke's Hospital, Bradford.
General Hospital, Halifax.
General Hospital, Harrogate.
Royal Infirmary, Huddersfield.
Maternity Hospital, Leeds.
Montagu Hospital, Mexborough.
Jessop Hospital, Sheffield.
General Hospital, Wakefield.

HEALTH VISITING

" 24.—(1) It shall be the duty of every local health authority to make provision in their area for the visiting of persons in their homes by visitors, to be called ' health visitors', for the purpose of giving advice as to the care of young children, persons suffering from illness, and expectant or nursing mothers, and as to the measures necessary to prevent the spread of infection."

The full-time establishment of staff authorised by the County Council to undertake the combined duties of health visiting, tuberculosis visiting and school nursing is 341. There are still 4 whole-time school nurses employed in the service, leaving an establishment of 337 at the disposal of the Health Committee. At the end of the year, the health visiting staff comprised 243 qualified health visitors, 37 unqualified, 24 part-time, 11 tuberculosis visitors and three nurses combining health visiting with home nursing and midwifery; a total equivalent to 304 whole-time workers, 33 fewer than the authorised establishment. A brief summary of their work over the year shows:—

No. of families visited	88,092
No. of children under 5 years of age visited	85,906

ANALYSIS OF VISITS.

Expectant mothers		9,141
Children—under 1 year	159,736	
aged 1—2 years	79,512	
aged 2—5 years	111,509	
		350,757
Tuberculous households		31,589
Other cases		150,273
School health		27,391
Ineffective		45,911
Total		615,062

CLINIC AND SCHOOL SESSIONS.

Maternity and Child Welfare	25,322
Ultra-violet light	3,164
Parentcraft	888
Specialist—chest	2,946
other	2,595
School health	30,320
Total ..	65,235

The added duties which health visitors have been called upon to undertake in relation to social work in hospitals and the care of the aged has necessitated re-adjustment to relieve them of many of the duties in relation to B.C.G. and poliomyelitis vaccination. Progress in the liaison between the health visitor and the general practitioner has been slow, although there are encouraging signs of a much better understanding, and even though the installation of the telephone has not yet proved to have fulfilled the purpose for which it was intended, it has been a definite help in establishing the identity of the health visitor in the area as a medico-social worker and a member of the health team.

There has been marked improvement in the link-up with other statutory and voluntary bodies, e.g. the National Assistance Officer and the Old People's Welfare Committees. Many health visitors are co-opted members of the latter, attend evening meetings and give up much of their own time in helping to organise social functions for the elderly.

The health visitor's contribution to the prevention of the break-up of the home has been most valuable and her success in this has been rewarding. Her early knowledge of the problems, her advice and guidance, the practical help which she so frequently obtains, have prevented many a catastrophe. The health visitors have taken a particular interest in the families which have had recuperative treatment at Spofforth Hall and Brentwood, and have given encouragement and guidance in order to maintain the standards of mothercraft which they have been taught. In individual instances, the health visitor has taken a particular interest in the cleaning, decorating and re-furnishing of the home for the return of the family.

Refresher Training.—To keep pace with modern trends in medicine and social reconstruction, refresher courses are essential for all nurses working in the public health field. In view of the enthusiasm created and the hidden talent brought forth by the course on " Teaching Methods for Health Education " conducted by Dr. Emrys Davies, Central Council for Health Education, in 1955, this course was repeated in 1956; 55 health visitors attended.

In addition, 30 health visitors attended outside courses organised and conducted by the Royal College of Nursing and the Women Public Health Officers' Association. The outside courses give ample scope for discussion and the interchange of ideas with health visitors from other parts of the country.

Four health visitors attended a two weeks' special course in the ascertainment of deafness in children, held at Manchester University and directed by Professor and Mrs. Ewing whose interest in the prevention of deafness is well-known. The health visitors came back imbued with great enthusiasm; they each compiled a paper on what they had heard and seen. They organised discussion groups on this subject in their divisions to which neighbouring health visitors were invited; the knowledge gained is proving an advantage to the health visitor in her work.

Group Lectures.—Owing to the concern nationally and locally of the high death rate of children due to accidents in the home, six lectures on ' Home Safety ' were arranged for midwives, home nurses and health visitors at Harrogate, Wakefield, Doncaster, Rawmarsh, Shipley and Brighouse. The prevention of accidents in the home is the concern of all nurses and the importance of constantly reminding the parents and relatives to avoid mishaps was very ably stressed by the speakers.

Supervisory Staff.—The two Superintendent Health Visitors have supervised the practical work of health visitors and school nurses and tuberculosis visitors. They spent much time in advising and guiding new entrants to the service, and also in promoting and encouraging group discussion and health teaching at infant welfare centres and schools. They also attended at divisional offices for appointment of staff, conferred with the Divisional Medical Officers and gave advice and guidance on the practical work of the health visitor.

Student Health Visitors.—Recruitment for health visitor training has not improved. The County Council has approved thirty students being selected for training each year but only ten students were accepted for the course at Leeds University; after completing three academic terms, they were all successful in the Royal Society of Health examination in July at Leeds. To keep pace with modern trends year by year, some re-adjustment in the practical side of the course is necessary. The whole-time West Riding Tutor makes personal contact with the field workers, and with their help, the practical programme is designed and kept up-to-date.

HOME NURSING

" 25.—It shall be the duty of every local health authority to make provision in their area, whether by making arrangements with voluntary organisations for the employment by those organisations of nurses or by themselves employing nurses, for securing the attendance of nurses on persons who require nursing in their own homes."

The 304 members of the staff doing home nursing at the end of the year consisted of 208 home nurses, 71 home nurse/midwives, 3 home nurse/midwife/health visitors, and 22 enrolled assistant nurses, 11 of the latter working part-time only; this is the equivalent of 261½ whole-time staff. 11 nurses completed approved courses of district training during the year and 5 others were under training at the end of the year; 53 new appointments were made and there were 29 resignations and 11 retirements.

Although there is a welcome improvement in the staffing of the service, it is pointed out that when due allowance has been made for leave of absence, for sickness and other reasons, there has been throughout the year an average employment of 245 whole-time staff which is 45 (or 16 per cent.) below the present aim of an establishment of 290 nurses.

A summary of the work shows 840,621 visits to 37,775 cases, a reduction of 5,783 visits and 1,888 cases as compared with the previous year; this confirms the view expressed last year that the demand for home nursing is now reasonably stabilised; increased staffing has been largely directed to ease areas where the nurses have been grossly overworked and there is also the impact of the additional week's holiday granted to all nursing staff. The proportion of nursing devoted to the aged increased from 42 to 46 per cent. of the cases and from 58 to 60 per cent. of the total visits. The following details give a brief summary and analysis of the work.

Type of Case Attended	*No. of cases attended*	*No. of visits by Home Nurses*
Medical	27,480	643,977
Surgical	9,209	159,061
Infectious Diseases	60	919
Tuberculosis	742	34,462
Maternal complications	284	2,202
TOTAL	37,775	840,621
Age Groups		
0-5	2,332	17,488
5-65	18,043	316,831
Over 65	17,400	506,302
TOTAL	37,775	840,621
Patients included above who have had more than 24 visits during the year	5,803	349,041

Visits for injections only, numbered 291,159 or 35 per cent. of the total compared with 32 per cent. in the previous year. In this connection, Dr. H. M. Holt, Divisional Medical Officer of No. 3 (Keighley) Division, writes:—

" I often feel that general practitioners are inclined to lean rather heavily on the home nurses in relation to ' injections'; be that as it may, the nurses work uncomplainingly and I have many complimentary comments both from general practitioners and patients."

Dr. D. D. Payne, Divisional Medical Officer of No. 8 (Harrogate) Division:—

" A large part of the duties of a home nurse are taken up by the giving of injections. During the year, no less than 11,051 injections were given (out of a total of 40,276 visits). There were 391 individual cases requiring injections which gives an average of 28 injections per patient during the year. This high figure is primarily due to the 58 patients who required daily injections of insulin."

The proportion of injection work varied from 7 per cent. in the Ripon and 19 per cent. in the Settle divisions, both rural areas, to 49 per cent. in the Rotherham and 53 per cent. in the Hemsworth divisions, both predominantly mining areas. This supports the impression that it is the doctors with large practices who most readily avail themselves of the assistance provided by the home nurse. It is a matter which has aroused considerable interest and Dr. A. L. Taylor, Divisional Medical Officer of the No. 16 (Rothwell) Division, writes:—

" There was very little demand for any injections in the 0–5 group, and such as there was consisted of antibiotics. In the other two age groups, however, antibiotic injections formed the largest single item of injection work this being very noticeable in the 5–65 group with a female/male ratio of 3 : 2. In the oldest group (65 plus) this was about 1 : 2. Streptomycin injections were, with one or two exceptions, confined to the 5–65 group. Generally, with the exception of streptomycin, injections were frequent over short periods.

Insulin was not used in the 0–5 group and very little used in the next group. In the 65 plus group there was a ratio of 3 : 1, injections usually being daily for an indefinite period.

Anaemia injections were in the ratio of approximately 3 : 2 in the 5–65 group. In the 65 plus group, it was also 3 : 2, but injections were given to many more patients. Frequency was usually weekly for a limited period but for much longer with the old people.

In the ' other ' injection group there was the most work with the old people, with cardiac conditions predominating. The injection ratio was about 11 : 9. In the younger ages, the home nurse was not required nearly so much, and the ratio here was 2 : 1. Visits were usually weekly with a continuing need."

Dr. A. Penman, Divisional Medical Officer for the No. 28 (Doncaster) Division, also writes:—

" The only distinctive feature of this work appears to be the preponderance of females, i.e. 65 per cent., throughout the entire age range. There is no great weight of cases in a particular age group.

More than three visits in every ten were paid for the main purpose of administering injections, of which antibiotics were the principal remedy involved. Anti-anaemia and insulin injections were the next most demanding in service."

An analysis of the injections given in the greater part of the County Area shows that 40 per cent. of them were antibiotics, primarily of penicillin preparations, but including also streptomycin for the home treatment of tuberculosis; antibiotics were given as often as twice daily. Anaemia followed with 20 per cent. of the injections and 17 per cent. were for cases of diabetes, generally involving daily injections. Sedatives represented 1 per cent. only of the total and the remaining 22 per cent. were for many miscellaneous conditions.

Forty-five visits were made to a patient resident in an aged persons' home, and 207 patients made 369 attendances at the nurses' homes.

A home nurse attending a general practitioner's surgery, gave assistance to 708 patients making 2,919 attendances; her work included 1,909 injections, 1,019 of these being antibiotics.

Domiciliary Service for Diabetic Patients.—Following a circular to Regional Hospital Boards from the Ministry wherein it was advised that Boards should inaugurate a scheme for the provision of special facilities for the treatment of diabetes, the Leeds Board, through its liaison Committee with Medical Officers of Health, agreed that it was desirable to provide some form of domiciliary service for diabetic patients. Hospital Management Committees were recommended to explore the possibility of providing such a service through the medium of a health visitor or home nurse who would act as liaison officer between the hospital and general practitioner. She would attend the consultant clinics at the hospital and ensure that instructions in regard to stabilisation were carried out in the home of the patient. She would also be responsible for teaching the technique of injection, urine testing, and the diagnosis and treatment of hypoglycaemia. Such liaison has been established with the hospitals at Halifax, Huddersfield, Pontefract and Castleford, and 213 patients were dealt with. Dr. E. Ward, Divisional Medical Officer of No. 20 (Colne Valley) Division, reporting on the service within his division states:—

" At the request of Dr. J. Walker Hirst, Consultant Physician, Huddersfield Royal Infirmary, a meeting was arranged between Dr. Hirst, Dr. J. M. Anderson, Senior Medical Officer, and the Divisional Medical Officer, to discuss the possibility of providing a Health Visitor to attend the weekly Diabetic Clinic at the Royal Infirmary and to follow-up West Riding cases as required by the Consultant Physician. The scheme has now been running for four months and is proving most helpful to the patients concerned and to the Consultant Physician.

The duties of the health visitor consist of attendance at the clinic one afternoon per week and visiting of patients in their homes as required by the Consultant Physician in concert with the general practitioners. All new patients at the clinic are seen by Dr. Hirst at their first visit. A full medical history is taken and the patient is examined. The health visitor is present during the interview and thus obtains a full knowledge of the patient's medical background. Dr. Hirst then gives instructions as to the treatment to be carried out. This is noted by the health visitor who visits the patient at home a day or two later to see if the instructions have been properly understood and are being correctly carried out. The patient is taught urine testing and injection technique. The diet is carefully checked and advice given on general care.

Further visits are paid to note the reaction of the patient to the treatment given and these are continued until the patient is stabilised and has a sound knowledge of the reason for his diet and the principles underlying his treatment. At each weekly clinic the health visitor reports to Dr. Hirst on the patients she has visited during the week. Patients of long standing are visited when a change of diet or insulin doses are required.

The service rendered is essentially educational and does not cover routine daily injections of insulin. These are given by the home nurses in cases where they cannot be given by the patient or friend. The majority of County patients attending the Diabetic Clinic at Huddersfield Royal Infirmary live in Division 20, but a small number come from Division 17 (Spenborough) and Division 18 (Brighouse). Patients from these areas are covered by the health visitor from Division 20."

Supervision.—Practical supervision has been continued by the two Supervisors who paid 372 routine and 145 special visits to nurses. They had frequent consultations with Divisional Medical Officers on the appointment of staff and on other matters affecting the local services.

Refresher Training.—It was again possible to arrange a week's refresher course, opened by County Alderman N. Carter, Chairman of the West Riding Health Committee, at the Adult College, Grantley Hall, which was attended by 45 home nurses. The focus was on " Promotion of Health in the Home", and Dr. J. Valentine, Medical Superintendent of the Scalebor Park Hospital, Consultant Psychiatrist to the Leeds Regional Hospital Board and to the United Leeds Hospitals, and Lecturer in Psychiatry at the University of Leeds, spoke on this subject in the inaugural address with later lectures on the " Psychological Aspects of Illness". " The Disturbances causing symptoms in Children " was the main theme of talks by Dr. W. Henderson, Paediatrician for the City of York. Dr. Henderson thought the home care of sick children should now be possible in view of the increased number of home nurses, and he stressed the importance of early discharge from hospital after a diagnosis had been made. We were indebted to the County Welfare Officer for an informative address and later discussion on " Social Welfare Administration". Other speakers were Mr. E. M. Birtwisle, Chief Public Health Inspector of the Horsforth Urban District Council, Miss F. A. Heaney, Regional Public Health Nursing Officer of the Ministry of Health, and Miss E. M. Herron, North Eastern Area Visitor for the Queen's Institute of District Nursing. Nursing technique was demonstrated by Miss J. Corcoran, Matron of the Queen's Training Home, Leeds. A profitable visit was paid to Messrs. Rowntree's Factory, York. In addition to a tour of part of the factory, a talk was given by Mr. I. H. Higham, Chief Industrial Psychologist, on the psychology of the worker, particularly the adolescent.

Housing.—Housing accommodation acquired by the County Council, largely from the former District Nursing Associations and augmented by the inclusion of flats in the adaptation of property for clinic purposes, is occupied by 31 home nurses, 11 midwives and 4 health visitors. District Council and private houses rented by the County Council for the nursing services are occupied by 74 home nurses, 43 midwives and 3 health visitors. Rental is charged of not more than that prescribed by the Whitley Council except where the nurse has a husband or other non-dependent persons living with her; in the latter case, an economic rent is charged with a maximum, inclusive of rates, of £65 yearly for unfurnished accommodation. For all cases, the County Council accepts responsibility for any necessary internal decoration when accommodation is first occupied by a nurse.

The question of the County Council erecting suitable houses for nursing staff has received careful consideration but has not been accepted in view of the complex nature of the problem; it will be necessary, therefore, to continue to rely on the friendly co-operation of County District Councils to provide additional houses where necessary, either by direct rental to the nurse or by rental to the County Council to sub-let to the nurse; the advantages of this policy are appreciated not least by the community in need of a readily accessible home nurse.

Motor car Transport.—156 home nurses are authorised to use their private motor cars for their official duties. Additionally the County Council has provided a fleet of 93 motor cars to be made available to nursing staff who do not possess a private car but need such transport for their duties. At the end of the year, 78 were issued to home nurses, 6 to midwives and 3 reserved for re-issue early in the year; one car is needed as a spare to meet urgent needs in case of extensive repairs being required, and the remaining 5 had been withdrawn from service as obsolete and requiring replacement.

Where a County car is issued to a nurse, she has the opportunity of also using the car for private purposes on payment of an agreed annual sum to the County Council; this concession is greatly appreciated by the nursing staff.

VACCINATION AND IMMUNISATION

" *26.—(1) Every local health authority shall make arrangements with medical practitioners for the vaccination of persons in the area of the authority against smallpox, and the immunisation of such persons against diphtheria.*

(2) Any local health authority may, with the approval of the Minister, and if directed by the Minister shall, make similar arrangements for vaccination or immunisation against any other disease."

Under Section 26, the Authority have approved schemes for vaccination against smallpox, immunisation against diphtheria, immunisation against whooping cough, and vaccination against poliomyelitis.

Details of the work done during the year under these schemes will be found in Part II of the Report under the heading of Epidemiology.

AMBULANCE SERVICES

" 27.—(1) It shall be the duty of every local health authority to make provision for securing that ambulances and other means of transport are available, where necessary, for the conveyance of persons suffering from illness or mental defectiveness or expectant or nursing mothers from places in their area to places in or outside their area."

The Service is under the charge of Mr. V. Whitaker, O.B.E., County Ambulance Officer, who has supplied the following report:—

	Year ended 31st December		*Variation on 1955*	
	1955	*1956*	*Increase*	*Decrease*
Admissions	40,572	41,448	876	
Discharges	29,555	29,059		496
Transfers	9,103	9,154	51	
Out-Patients	347,573	348,145	572	
Accident Patients	12,205	12,741	536	
Children to Occupation Centres	965	172		793
Total of Direct Service	439,973	440,719	746	
Total of Direct Service, Agency and Car Pool Services	470,395	472,769	2,374	
Total Mileage	3,299,971	3,249,417		50,554

The increase in the number of ambulance users during the year under review is the smallest since the inception of the Service under the National Health Service Act, 1946 and it would appear that demand may now have reached a constant level. Throughout the year close co-operation with Hospitals has been maintained in an endeavour to reduce unnecessary journeys and obviate misuse of ambulances, whilst at the same time providing the best possible service to the public.

Further improvements have taken place regarding radio vehicle control and telephone communications. Radio monitor sets have been installed at more depots to enable those depots to hear movement reports of their own vehicles. Schemes have been formulated for improving radio control in the two areas covered by Barnoldswick, Settle, Skipton and Castleford, Goole, Wakefield, South Kirkby depots by installing a separate transmitter for each area and the linking of depots to the transmitting station by direct telephone lines.

The building of the new Vehicle Maintenance Workshop at Birkenshaw has progressed steadily and it should be ready for occupation by June, 1957.

Plans are in hand for the building of improved depots at South Kirkby, Hoyland and Skipton and a new one at Penistone.

Experiments with Diesel-engined ambulances resulted in the conclusion that the B.M.C. 2·2 litre engine is the most suitable for our purposes and by the 31st March, 1957 there will be 32 Diesel-engined vehicles in service, 28 being powered by this engine, which, in the type of vehicle being used, gives a 50 per cent. increase in miles per gallon over the equivalent petrol unit.

Fibre glass construction of parts of ambulance vehicle bodywork has been pursued successfully in co-operation with certain vehicle body builders and has now been incorporated in the latest ambulances purchased.

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

" 28.—(1) A local health authority may with the approval of the Minister, and to such extent as the Minister may direct shall, make arrangements for the purpose of the prevention of illness or mental defectiveness, or the after-care of such persons, but no such arrangements shall provide for the payment of money to such persons, except in so far as they may provide for the remuneration of such persons engaged in suitable work in accordance with the arrangements."

Health Education

An essential part of any national health policy is the instruction in the principles and practice of how to achieve perfect health of mind and body. For many years the administration and practice of preventive medicine was confined largely to two principal spheres: that of the environment and that of infectious disease, but since the turn of the century there has been a change in the orientation of public health activities with attention now being directed more and more to the individual and to ways in which he can be influenced to obey the laws of healthy living.

Education to achieve good health is not new; for centuries the fundamental idea of those engaged in preventive medicine has been that the first duty of medicine is not to cure disease, but to prevent it. John Wesley, who was possibly the greatest health educator of the 18th Century in Britain, included health education in his evangelism; he believed that to derive most happiness from life a person must be healthy as well as godly.

Good health and healthy living is not only a physical state but also a mental one so that it behoves all in preventive and curative medicine alike to exercise every effort to coax, persuade and convince people exactly what good health is, how it can be acquired, and how it can be maintained. Although mentioned separately here, health education is interwoven with all the activities of the Department and with the subjects dealt with in this Report.

In an Administrative County the size of the West Riding with its varied concentrations of population there can be no common or rigidly applied measures for imparting the fundamentals of health education. It is apparent that our propaganda efforts, to gain maximum results, must be directed along the channels most suited to the area. In the sparsely populated areas certainly the most important health educators we have are the health visitors and nurses who in the home and in the clinic, through personal advice, talks, demonstrations and discussions, can sow the seeds of healthy living. Their efforts can be and are reinforced by the teaching of children in schools. To some extent the same applies in the more densely populated areas but more opportunities present themselves for utilising visual aids.

During the year over 41,500 leaflets, cards and poster stamps covering a wide range of subjects were distributed to the public by the various members of the health team and over 800 posters and picture sets were displayed in clinics, hoardings and shop windows throughout the County. The majority of the leaflets etc. were those of the Central Council for Health Education, the Royal Society for the Prevention of Accidents and the Ministry of Health. A representative collection of film strips is kept at headquarters from which Divisional Medical Officers and their staffs can borrow and judging from the requests received it is apparent that this type of visual aid is proving most useful. Talks on a variety of subjects, in many cases illustrated by visual aids, have been given by Divisional Medical Officers and their staffs at schools, clinics and meetings of parent-teacher associations, in fact no opportunity is lost to enter new fields and try to influence as wide an audience as possible to secure and maintain a healthy way of living.

Divisional Medical Officers have again co-operated with the Central Office of Information in the insertion of advertisements in local newspapers drawing attention to the safeguards afforded by diphtheria immunisation and the necessity to maintain a high level of immunisation in the child population.

The responsibility of organising health education propaganda within the Divisions rests with the Divisional Medical Officers and Dr. F. Appleton, Division 18 (Brighouse), reporting on the activities in his Division writes:—

" Perhaps the most important regular contribution to health education is talks by the health visitors in schools on mothercraft to senior girls. This was offered to all the senior girls but in some schools it is undertaken by the domestic science teachers. As long as a teacher follows a suitable syllabus, it may be that what she lacks in nursing knowledge is compensated for by her ability to teach and her teaching experience. The health visitor, on the other hand, has nursing knowledge but may lack teaching experience, and consequently lectures are given to senior girls both by mistresses and health visitors. A happy arrangement exists in Greetland School, where the health visitor works with the domestic science mistress.

One of my health visiting staff, Mrs. Hepworth, after attending a course at Bradford, was successful in passing her examination and obtained a certificate for teaching health education.

Group training at the infant welfare centres is not attempted on a large scale, and more reliance is placed on individual teaching and posters. At the special relaxation clinics a very important contribution is made to health education. The mothers are taken through a regular course of eight sessions in which they are taught all about the precautions they should take during the ante-natal days, and taught about the delivery and about the care of the new baby. At the Day Nursery too, regular opportunity is taken by the Matron of instructing the mothers, particularly where the children are not well cared for.

The home nurses take an opportunity of instructing relatives and patients in the maintenance of proper diet, and in urine testing, etc., in cases of Diabetes.

The main health education is, of course, done by the health visitors in their regular routine visits to normal families. One of the health visitors has made a series of posters illustrative of different aspects of health education, and the posters of the Central Council are also displayed. It is important that these posters should be changed regularly, and their position changed, as people soon get used to seeing the same poster placed in one position without really looking at it. The posters are used as talking points.

It has been found extremely difficult to give a systematic series of talks on health education in the child welfare centres because of the constant interruptions both by children and adults.

We have established a home safety committee in the Brighouse Borough, and among the activities have been a free flag day, exhibition of a safety room at various functions, a children's poster competition, and a lorry with a home safety exhibit taking part in a procession. Christmas posters and posters at the season of the Gunpowder Plot were displayed widely throughout the town. Talks were given in connection with this Committee at the seven old people's clubs. In addition, talks on health matters have been given to the following groups during the year:— The Round Table, Parent-Teacher Associations (3), Townswomen's Guilds (2), Men's Fellowships (2), Youth Organisations, and various Child Organisations."

Commenting on the work undertaken in his Division, Dr. N. V. Hepple, Division 7 (Ripon), reports:—

" The basic health education in this Division is done by the health visitor, who is the only public health officer to visit the home regularly, and is thus able to give specialised health education in the place where it is needed.

Courses for senior girls have been run in two schools in the Division by health visitors. Child care and home management were covered, and the schools concerned seem to appreciate the information given.

Film strips and sound films have been used to reinforce teaching at schools and clinics.

During the year I gave short talks at two parent-teacher associations on poliomyelitis vaccination. Discussions followed and all concerned probably learned something. I also gave a talk on Home Safety to mothers at a large military camp in Ripon.

Poster displays on special topics are organised at the Divisional Health Office and at the clinics. There is no doubt that series of posters which tell a connected story are read by the public, because I have been surprised at the number of people I have myself seen reading the stories we display in the street in Ripon.

Relations with the Press have been good. Any special announcement made at Council or Committee meetings has always been given any desired publicity, and my impression is that the local paper is a good way of getting in touch with people."

With home accidents continuing to provide a depressing picture it would seem that the educational work undertaken in the past had little effect on the situation. A new approach to the problem has been made and arrangements have been completed with a publishing firm to produce handbooks on home safety for certain Divisions, drawing attention to the hazards and offering hints and advice. During the year the handbooks were available for only one Division but the publication of handbooks for further Divisions is proceeding and during 1957 it is anticipated that upwards of 40,000 copies will have been distributed.

Tuberculosis

There is no diminution in the ceaseless activity directed towards the prevention of tuberculosis and the care and after-care of those who suffer from this disease. A selection of reports from the Divisional Medical Officers, including reports of a number of chest physicians, are given and reveal the many differing aspects of the problem.

Dr. M. Hunter, Division No. 1 (Skipton)—

" There was no known case with a positive sputum in employment in the area, and only one case with a persistently positive sputum which it seems impossible to convert. A close liaison is maintained with the Divisional Rehabilitation Officer and, in a large percentage of cases, it is possible to get the patient back to work with his previous employer.

All school entrants (i.e. five-year-olds) were offered a tuberculin jelly test and 632 accepted. Of these, 52 gave a positive reaction and were referred to the Chest Physician who examined them and their contacts.

It is considered that where the milk supply is satisfactory it should be possible in most cases to discover the adult source of infection. In one small urban district 28 children were found to be tuberculin positive, and 23 of these had the same milk supply. Of these 23, 4 developed tuberculous glands and 1 tuberculosis of the wrist. On enquiry from the Ministry of Agriculture, Fisheries and Food, it was found that there had been a serious breakdown in the T.T. herd supplying this milk, and direct infection seems a fair assumption. This matter was taken up with the Ministry of Agriculture, Fisheries and Food, but apparently there is no procedure whereby the Medical Officer of Health can be notified of such breakdowns. The position is obviously very unsatisfactory. Children giving a positive tuberculin reaction are kept under observation by the School Medical Officers or the Chest Physician, or both.

Special case finding surveys have been limited to—

(i) tuberculin testing at ' birthday ' examinations at certain child welfare clinics.

(ii) tuberculin testing of ' five-year-olds'.

(iii) Visit of a Mass Radiography Unit to the area.

There is no Care Committee in this largely rural area. We doubt if the time involved in organising and operating it would be justified by the results these days. However, the health visitors continue to act as clinic nurses at the two chest clinics in the area, on a rota basis. This satisfies the Chest Physician, gives the health visitors a close insight into all the work there, and helps co-operation with the Hospital Board Services. Furthermore, a case conference is held every 4 to 6 weeks attended by the Chest Physician, Divisional Medical Officer, and the Health Visitors. Here every new case is reviewed, and the progress of other cases discussed.

Home helps are available when required but the demand for their services by the tuberculous remains small.

Occupational therapy is still handicapped by a lack of teachers."

Dr. H. M. Holt, Division No. 3 (Keighley)—

" All known contacts of cases are examined if willing to attend for X-ray examination; children are jelly tested as well and suitable cases offered vaccination. Children giving a positive reaction to a jelly test are kept under observation for two years.

There are no After-Care Committees operating in Keighley nor does there seem to be any need for them. Patients who require financial assistance and/or clothing are referred to the National Assistance Board, who have proved very helpful.

Every effort is made to find suitable employment for patients returning from Sanatorium. Here the Divisional Rehabilitation Officer has always been very helpful and employers are quite co-operative.

No significant change has taken place in the past year and although there may be some empty beds in Sanatoria, the work of the Clinic has not diminished to any extent. It would seem that the main emphasis in the future will be on prevention and finding and dealing with positive cases who are a reservoir of infection and the B.C.G. vaccination of child contacts and school leavers."

Dr. D. D. Payne, Division No. 8 (Harrogate)—

" In relation to the preventive and after-care services as a means of controlling tuberculosis in this division, consultative sessions have continued to be held four times weekly at Scotton Banks Hospital and four times weekly at the Chest Clinic, 10 North Park Road, Harrogate. Of the latter, the special children's bi-weekly sessions inaugurated in June, 1955, have shown an increasing number of attendances and at these clinics 80 child and adolescent contacts have been given B.C.G. vaccination.

Close liaison has continued between the Clinic and the Ministry of Labour and full co-operation is maintained in placing tuberculous patients in employment suitable to their health and to that of their fellow employees.

The Tuberculosis Care Committee working in this area met quarterly during 1956 to discuss cases referred for help and to grant assistance where necessary. The number of cases in the Harrogate Division who received assistance from the Tuberculosis Care Committee during 1956 was 14. In addition, 30 gift parcels were distributed at Christmas time to deserving cases."

Dr. J. M. Paterson, Division No. 11 (Castleford)—

" The ratio of contacts seen by the chest physician to the number of cases notified during each of the past three years is shown in the following table:—

Year	No. of actual cases	No. of contacts	Ratio
1954	57	133	1 to 2·33
1955	50	129	1 to 2·58
1956	31	*109	1 to 3·51

* Of the 109 contacts who were examined, none required any further active investigation.

No particular problems have arisen in regard to employment conditions. During the year six men and two women attended a course of rehabilitation. In addition, one female who is a quiescent case of tuberculous meningitis, is working at a local basket factory.

In 1956, following representations made by the Castleford Borough Council to the Regional Hospital Board, facilities were made available for a special survey for the mining community to be held in the precincts of three of the four pits in Castleford. This fourth pit was left out because it had already been included in the 25 pit scheme recently inaugurated by the National Coal Board in an effort on their part to gain detailed experience and information of the conditions existing in the 25 selected pits in England and Wales. This survey of the three pits in Castleford was a direct follow-up of the previous survey held in 1953 and the sequence of events closely followed the same pattern as in the first survey. Up to 1953 there had been no consistent policy in regard to the periodic X-ray of the mining community in this Division, and it was felt that if we were to gain the full confidence and support of the miners, a different technique would have to be adopted from that normally employed. Following negotiations with the National Coal Board, a team consisting of the Chest Physician for the Division, the Medical Officer of Health, and the Area Organiser of the M.M.R. Unit, met the pit Consultative Committees composed of representatives of management and men at each pit and discussed problems and difficulties arising during the preliminary contact normally made by the M.M.R. Organiser alone which was made with the collieries to ascertain the number of those willing to be called for X-ray. This arrangement appeared to work very well indeed and in all probability was the means of attracting a larger number of men for X-ray than would otherwise have been the case. In the survey held in 1956, a team consisting this time of the Area Medical Officer for the National Coal Board, the local Medical Officer of Health, and the Area Organiser, again visited each of the Consultative Committees and again discussed any problems or difficulties relating to the forthcoming survey in the same manner as on the previous occasion. Comparing the two surveys, one could not but be struck by the different attitude which existed—on the first occasion it appeared to be that of ' Why pick on us ', whilst on the second occasion it was ' What can we do to help you to make this a great success?'

Useful comparative figures of the two surveys are rather difficult to give, firstly, because in the survey of 1953 all four collieries in Castleford and one in Normanton were included, but owing to accommodation difficulties at one of the collieries, the survey for this particular colliery had to be held in another Divisional area, whereas in 1956, accommodation at this particular colliery was available, but as has been mentioned above, one of the collieries in Castleford was excluded as it had already been included in the 25 pit scheme, and the Normanton colliery had been dealt with in the previous year when a general survey was held in that area. In this way only three instead of five pits were dealt with. Secondly, a different classification of results is now being used.

M.M.R. Survey of Collieries in 1953

(4 Colleries in Castleford and 1 Colliery in Normanton)

Total number of miners who were X-rayed	2,975
Number of miners who could have been X-rayed	8,321
Percentage X-rayed	35·8
Number presumed active	13
Rate presumed active, per 1,000 examined	4·4
Number presumed inactive	26
Rate presumed inactive, per 1,000 examined	8·7

M.M.R. Survey of Collieries in 1956

(3 Collieries in Castleford)

Total number of miners who were X-rayed	2,355
Number of miners who could have been X-rayed	5,057
Percentage X-rayed	46·6
Number presumed active	3
Rate presumed active, per 1,000 examined	1·3
Number presumed inactive	17
Rate presumed inactive, per 1,000 examined	7·2
Pneumoconiosis	87
Pneumoconiosis, per 1,000 examined	36·9

Until it becomes possible to get 100 per cent. attendance at such a survey, the results of any survey of such a nature are bound to be haphazard and somewhat unsatisfactory, but in spite of this it is gratifying to find that in the 1956 survey there was a considerably better all-round attendance of the men for X-ray. Presumably if the same pits had been covered as was done in 1953, the same overall figure again would have been increased for 1956. It is interesting to note, however, that the rate per 1,000 of those examined in 1953 was 4·4, whereas in 1956 this had dropped to 1·3. The pneumoconiosis figures shown for 1956 are interesting and indeed a little startling.

In endeavouring to assess the amount of good work that the T.B. After-Care Committees have done in this Division, two sets of factors must be kept in mind, both of which are the product of the type of district and indeed the one dovetails into the other. Three years ago, when a special M.M.R. survey was held in all the pits in this Division, an effort was made, as is mentioned above, in detail, to interest the miner in the why and wherefore of M.M.R. surveys. It was found at that time that a certain amount of hostility was being manifested, entirely due, in my opinion, to the fact that this was the first co-ordinated survey of this nature which had been held in this Division, but during the intervening three years, the miners had come to realise more and more that a particular problem existed as regards tuberculosis and that of necessity it could very well affect them individually, and it was again particularly noticeable when the second survey was held in Castleford that there was a more open attitude towards the whole subject of tuberculosis. Again, in a community such as we have in this Divisional area, which is essentially mining in character, pulmonary tuberculosis is just another of the deadly diseases. To the miner, pulmonary tuberculosis has probably the same impact as cancer in that it is something which he has read about, or it is a condition one of his friends has suffered from, but it certainly does not go deeper than that. On the other hand, pneumoco-

niosis is a far more tangible condition of which he has real deep-seated understanding, extending right from the time when he entered the pit (and possibly even before) and he knows full well that the whole gamut of his disablement ranges from a mild shortage of breath—and a surface job—to extreme dyspnoea carrying a disability pension. Such then is the background which has played such a prominent part in influencing the financial extent of the activities of the T.B. After-Care Committees. So long as the emphasis of this movement was focused on tuberculosis alone, the amount of active interest it engendered was not particularly great and in consequence it operated in an atmosphere of relative impecuniousness. Progress however can never be static and in the light of modern experience it was found necessary to include not only pulmonary tuberculosis, but also advanced chest and heart lesions within the ambit of its activities. In this way it became readily apparent that as soon as the local committee accepted the more up-to-date interpretation which, to the mining community, meant pneumoconiosis, it soon became more noticeable that the attitude of the general public was much more sympathetic than previously. As a result of this it has become possible to organise ventures which range from pit head collections and concerts at Working Men's Clubs on the one hand, to whist drives and sports charity matches on the other. It is needless to say that these extra funds have gone a long way towards providing extra and additional amenities for all those coming within this category and in need. During the year a total of £362 12s. 7d. was spent in assisting 138 people.

A service has been inaugurated by the Chest Physician, Dr. Jordan, who, working in conjunction with the local Paediatrician, holds joint sessions in regard to suspect paediatric cases. During the year at least one most interesting case came to light as a result of the operation of this clinic. A child was found to have a primary lesion and on investigation of the contacts it was discovered that one of the parents proved to be a case of active pulmonary tuberculosis.

There can be little doubt that much of the resulting ennui during convalescence from an acute disease, and particularly so from a long drawn-out chronic infectious disease like pulmonary tuberculosis, is consequent on a mental boredom. It is not everyone who can while away his time hour after hour, day after day, and week after week, by means of reading material, and for these people it is desirable that some alternative regime should be worked out in an effort to relieve this monotony. Occupational therapy has proved an immense success to those suffering from a physical or mental handicap and there is every reason to believe that such methods could successfully be modified to fulfil the requirements of convalescent cases of pulmonary tuberculosis. A pilot scheme of this nature was begun in this Division at the latter end of 1955, and a handicraft instructress was put in charge. Reports which are now coming to hand all indicate that this form of therapy has been extremely well received by most types of convalescents and it is hoped that the activities will be extended before long. During the year, an average of 13 patients were declared fit by the Chest Physician in charge that they could safely take up the particular type of therapy for which they were considered most suitable. Some of those engaged on this diversional therapy have made cane hanging baskets, plant stands, electric light shades and sea-grass stools, whilst others have done embroidery and knitting. Now that the Tuberculosis After-Care Committees have greater funds at their disposal, there is a feeling that something could be done by this body in providing at least some of the raw materials necessary for diversional therapy and also possibly equipment for use by these cases.

For a few years now, a liaison has been maintained between the local Maternity Home and one of the health visitors on the staff attends regularly to receive and to impart information concerning patients admitted to and discharged from the Home. In conjunction with this scheme the tuberculosis health visitor in this Division has co-operated with the health visitor who visits the Maternity Home and as a result of this tie-up two women who were on the T.B. register were found alternative accommodation for their confinements in suitable premises."

Dr. W. M. Douglas, Division No. 17 (Spenborough)—

" Tuberculin jelly testing of school children was commenced in September and arrangements were made to carry this out on school entrants and children in the seven to eight year group. A letter of explanation and consent form were sent by the teachers with the Form N.P. to the children in these groups when they were due for medical examination at school. These were returned to the school and the school nurse applied the tuberculin and control jelly to those children whose parents had consented to this procedure being carried out, three days before the school medical inspection was due to be held. The School Medical Officers read these results when the children were presented for medical inspection and the implications were explained to the parents. Where the jelly test proved to be positive, the children were invited to the school clinic for a further skin test, and, where this again proved to be positive, the tuberculosis visitor was informed and she arranged for follow-up of the child and contacts at the chest clinic.

I give below the results of the jelly tests for the year ended 31st December, 1956—

New Entrants	Boys	Girls
Number offered jelly testing	113	92
Number of acceptances	97	84
Percentage of acceptances	85·5	91
Result of test:— (a) Positive	2	4
(b) Negative	95	80
Percentage:— (a) Positive	2	5
(b) Negative	98	95
Result of final skin test:—		
(a) Positive	1	2
(b) Negative	1	2
7/8 Year olds		
Number offered jelly testing	66	79
Number of acceptances	61	67
Percentage of acceptances	92·5	85
Result of test:— (a) Positive	7	9
(b) Negative	54	58
Percentage:— (a) Positive	11·5	13·5
(b) Negative	88·5	86·5
Result of final skin test:—		
(a) Positive	4	4
(b) Negative	2	4
(c) Not ascertained	1	1

Total number of children X-rayed	11
Total number of contacts X-rayed	63
Number of new cases of tuberculosis discovered	Nil

In a number of cases parents volunteered information about their relatives who had suffered from tuberculosis and who may possibly have been the original source of infection. It is, however, also true that this area did not become ' specified ' for the sale of specially designated milk until 1954."

Dr. F. Appleton, Division No. 18 (Brighouse)—

" During the last three years, we have been working with a system of special contact cards, one for each known contact, and an effort is made for all contacts of new cases to have an investigation, including X-ray. Other contacts are followed up regularly and appointments are made for their X-ray whenever the Mass Radiography Unit visits the district. The number of known contacts is 702, there being 375 in Brighouse, 206 in Elland and 121 in Queensbury. This figure is in respect of 372 of the pulmonary cases on our registers. It is our usual practice, with the consent of the patient, to arrange for the X-ray examination of any workmates who have come into close contact with a new case of tuberculosis, and a particular check is made on the employment conditions of known cases of tuberculosis who have a positive sputum, or show signs of active disease. We were particularly concerned with a case of tuberculosis in a public house but were able to persuade the sufferer to be admitted to hospital, and workers in the public house were examined as contacts. In another case, where the man was a lodger, the landlady and her husband and family and other lodgers were examined as contacts. We do not allow any known contacts to miss investigation unless a complete refusal is encountered. Such refusals are rare and are usually overcome by co-operation between the Health Visitor, the Medical Officer of Health and the Family Doctor,. who each try persuasion on such occasions.

This year, 43 respiratory cases were notified, 25 in Brighouse, 10 in Elland, and 8 in Queensbury, and 7 non-respiratory cases, 4 in Brighouse, 2 in Elland, and 1 in Queensbury. In addition, there were four inward transfers of respiratory cases and two of non-respiratory. It will be noted that this year there was an increase in the notification rate in Brighouse and a considerable decrease in Elland. These figures must be considered in relation to visits of the Mass Radiography Unit. This Unit visited Elland last year when seven cases were found. This year it visited Brighouse and 11 active cases were found and subsequently notified. Without these cases the incidence in Brighouse would have fallen.

Of the new cases this year, 113 known contacts (77 adults and 36 children) had a large film X-ray examination at the Chest Clinic at Halifax Royal Infirmary. From these X-rays, 3 cases were notified, 2 adult females and 1 child. A special effort was made to follow up cases in a local brickworks where a large number of cases were found the previous year, and arrangements were made through the management and the Mass Radiography Unit that special mass radiography sessions would be held at the brickworks during 1957.

Six child contacts received skin tests. These were all negative, and sixteen children received B.C.G. vaccination, including ten newly-born children, who were not previously given a skin test. It was usually possible to adopt a policy of segregation for the children who had been vaccinated.

At the end of 1953, a Care Committee was formed for the whole Division and this Committee has received remarkable support including help from the Councils of Brighouse, Elland and Queensbury and Shelf. It has done excellent work. It has brought hope and the feeling of being thought about by others to a great many people. The work of the Care Committee is still very necessary, for any person who gets tuberculosis has to endure a period of frustrated hopes and lost ambitions, of anxiety and worry. He may have long months without earnings and may well give way to despair, a despair which affects his whole family as well as himself. This is the time when he needs help and assistance and this the Committee tries to give. Thirty-eight patients were helped by purchasing such items as bed linen, pyjamas, blankets, pillows, shirts, underclothing, shoes, etc. In a special case, where the patient who was also diabetic was confined to bed in what were to be the last months of her life, we supplied wallpaper and paint to decorate a room and arranged for a kind person to carry out the work. Mattresses were supplied in certain cases, free of charge, by the courtesy of a local firm of mattress manufacturers, who take old mattresses in part exchange. They supplied them after cleaning and renovating. At regular monthly intervals about 60 food parcels are sent out to patients with young families, and at Christmas time 40 parcels containing Christmas fare were sent. These contained those items which are normally on everyone's table at this festive tide, but yet may have been missing from these homes. An outing was arranged to Blackpool for people who had had neither the means nor the chance to have a holiday for a number of years. An attempt was made to run a diversional therapy service, and for those few who were able to participate in this scheme it was a great help. Many of the patients have already been trained in diversional therapy and we were able to supply materials to these. In addition to this help of the Committee we have been able to give intangible help in many ways, e.g. many people have been advised how to obtain additional assistance from the National Assistance Board, others have been able, by co-operation with employers and the Ministry of Labour, to find suitable employment when sufficiently well to work again. The patients themselves have frequently expressed their gratitude for the services of the Care Committee. The Library Committee of the Brighouse Corporation have very kindly given us a regular supply of books which are usually retained by the patient after perusal. When returned they are passed from non-active to active cases. We have now a sufficient library to satisfy most tastes. During 1956, the activities of the Care Committee were widened to include patients suffering from other respiratory diseases and chronic cardiac cases. Five such cases were helped during the year. This increase in activities is welcomed but it will not be allowed to interfere with our primary task, that of helping the tuberculous patient and his family. One case we helped was under the impression that he suffered from tuberculosis, although his wife and the Committee knew that he actually suffered from advanced carcinoma of the lungs. We were very pleased that we were able to help him when he applied for help and not leave him wondering why he of all tuberculous patients should be left out.

Jelly tests were done on 127 children who were recommended for artificial sunlight treatment. All these were negative. Primary skin testing and B.C.G. vaccination were offered to 584 school children who had attained the age of thirteen. The parents of 290 of these children agreed and Mantoux tests were carried out on 279. Of these, 96 were positive and 183 negative. All the children who had negative Mantoux tests were subsequently given B.C.G. vaccination."

Dr. J. Lyons, Division No. 19 (Todmorden)—

" The tuberculin survey of infants born in Sowerby Bridge, 1953–4, to which previous reference has been made covered these infants until they attained the age of two years, and was completed in September 1956. The results are outlined in the following summary:—

Total live births, Sowerby Bridge U.D., between October 1st, 1953, and September 30th, 1954	268	
No. of infants whose parents consented to survey	223	(83·2%)
„ „ „ refused survey	30	(11·2%)
No. of infants who have received (or who are receiving) periodic tuberculin tests	213	(79·5%)
No. of infants eliminated from survey by reason of removal from district	41	(15·3%)
No. of infants eliminated by reason of death	6	(2·2%)
„ „ „ „ B.C.G. vaccination as contacts of known cases	5	(1·8%)
No. of positive reactors discovered	2	(0·7%)
Approximate number of tuberculin tests performed	1,496	

Of the infants included in the survey only two were found to be positive reactors and no other child in this age group was notified as a case of tuberculosis. As was reported in 1955, these two infants were investigated clinically by the Chest Physician and a search was made for the source of infection. Nothing was found in the first case, but in the second both the mother and an elder brother were found to be infected and all three were admitted to sanatorium for treatment, with favourable results. An interesting point revealed by the survey was that although 30 per cent. of the infants were exposed to raw undesignated milk, in no case could infection be attributed to consumption of such milk."

Dr. E. Ward, Division No. 20 (Colne Valley)—

" The Divisional Area is served by two Chest Physicians, by Dr. H. S. Bagshaw, of Oldham, for the Saddleworth Area, and by Dr. R. N. Walker, of Huddersfield, for Colne Valley, Denby Dale, Holmfirth, Kirkburton and Meltham. There is close co-operation with both these Chest Physicians.

When a case of tuberculosis is notified, the health visitor concerned is informed. A home visit is made to ascertain contacts and to enquire which of these are going to attend the chest clinic for examination. Every effort is made to persuade unwilling contacts to agree to examination. The list of contacts along with the environmental report is then forwarded to the Chest Physician who arranges interviews for those willing to attend. A special contact session is held weekly at the Huddersfield Chest Clinic and a special weekly children's session is held at the Oldham Chest Clinic, to follow up child contacts and cases. In addition to excluding the presence of tuberculosis in contacts, Mantoux testing is carried out and B.C.G. vaccination offered in suitable cases. All contacts are re-examined periodically for as long as they care to attend and in this way supervision of children is continued as far as possible into young adult age when supervision of this kind is most important.

With regard to the Saddleworth Area, Dr. Bagshaw has supplied me with the following particulars:—

(a) Ascertainment of contacts in relation to notified cases for 1956:

	Children	Adults	Total
No. of accepted cases of pulmonary tuberculosis ..	1	8	9
No. of contacts of these cases	6	15	21
No. of contacts examined	1	8	9
No. of cases of tuberculosis found	—	—	—
No. of accepted cases of non-pulmonary tuberculosis ..	—	4	4
No. of contacts of these cases	—	6	6
No. of contacts examined	—	2	2
No. of cases of tuberculosis found	—	—	—

(b) Employment conditions of known cases of tuberculosis in relation to their health and that of their fellow employees.—It is difficult if not impossible to keep an up-to-date record of the occupation of all patients on the Register and even if the current occupations were known in every case it is often impossible to say whether the job is suitable both for them and their fellow workers without actually visiting their place of work and seeing them at work. It is also difficult in some cases to get an up-to-date sputum report. A patient may fail to attend or if he does attend he may fail to submit sputum samples on request or he may deny having any sputum in which case one has to accept his word for it. No persons on the Register at present are known to be working in obviously unsuitable jobs.

No special case finding surveys took place in the Saddleworth area and there has been no contact with any Care Committee. In view of the decreasing demand for in-patient accommodation, the Manchester Regional Board are now prepared to admit cases from the Saddleworth Urban District to nearby sanatoria in their area.

With regard to the rest of the Divisional Area, Dr. R. N. Walker has supplied the following information:—

' I find that out of 600 contact examinations, including re-examinations, from your area during the year 1956, six cases were found to be suffering from significant pulmonary tuberculosis. All these cases have done well on prompt modern treatment.

With regard to employment conditions of known cases of tuberculosis, we are now in the happy state of being able to quickly stabilise the disease and render the patient non-infectious. In this area the demand for labour exceeds the supply of workers and so there are few cases of pulmonary tuberculosis, once stabilised, who need be long out of employment.

During 1956 there has been no significant development in the Service, as it was found that existing arrangements for contact finding, both among adults and children, were adequate. Not only are immediate house contact cases investigated, but any reported outside contact, for example, at work, is followed up and cases of primary tuberculosis, although not strictly notifiable, are also used as a basis for case finding.

The low level of the tuberculosis death rate which has been maintained during the year, has been accompanied by a satisfactory, although slower fall in notification rate and it would seem that we are now justified in saying that tuberculosis is coming well under control.'

A case finding survey was conducted among pupils attending a Junior County School.

In May, 1956, a notification was received to the effect that a Head Teacher at a Junior County School was suffering from tuberculosis. After consultation with the Chest Physician, the possibility of infection was explained to the parents of all the children in the school by letter, and, with the co-operation of the Medical Director of the Mass Radiography Unit, radiological examination and Mantoux testing were offered for the children. Practically all the parents accepted the offer. None of the miniature films of the children or staff showed anything suspicious but amongst the 143 children Mantoux tested, 15 were strongly positive. The parents of these children were interviewed by a School Medical Officer and the significance of the testing was explained to them. In 7 of the cases a history of possible significance, e.g. cough, loss of weight, lassitude, etc., was obtained and these were referred to the local Chest Physician. The rest were advised to consult their family doctor immediately should they become suspicious of anything being amiss. No evidence of clinical infection was found in the group referred to the Chest Physician, and all have since been discharged apart from 2 who were already being followed up owing to a previous contact. All the Mantoux positive children are still being followed up in course of routine school medical inspection. In view of the length of closeness of contact it seems remarkably fortunate that more children were not found to be positive and no evidence of infection came to light."

B.C.G. Vaccination.—(a) CONTACTS.—A further 1,003 contacts were successfully vaccinated under this scheme during the year; in 9 more cases, vaccination was not successful. Details are given in the following table:—

	AGE GROUPS												All Ages
	Under 1 year Months				Years								
	0–	1–	3–	6–	1–	2–	3–	4–	5–	10–	15–	20–	
Vaccinated:													
Male	59	55	47	48	49	39	23	27	72	85	33	3	540
Female	68	44	44	68	49	41	38	31	86	85	50	28	632
TOTAL	127	99	91	116	98	80	61	58	158	170	83	31	1,172
Result of Vaccination: Successful:													
Male	58	48	36	38	41	32	20	25	59	70	26	1	454
Female	63	38	37	51	44	34	37	28	76	75	38	28	549
TOTAL	121	86	73	89	85	66	57	53	135	145	64	29	1,003
Unsuccessful ..	1	—	4	1	—	1	—	—	2	—	—	—	9
Not finally ascertained	5	13	14	26	13	13	4	5	21	25	19	2	160

(b) SCHOOL CHILDREN.—B.C.G. vaccination of thirteen-year old school children was being undertaken in 24 divisions and is expected to be available throughout the whole of the Administrative County area in the near future. 6,667 children were successfully vaccinated without untoward incident, although Dr. D. D. Payne, Division Medical Officer of No. 8 (Harrogate) Division, reports, " A girl had rather severe reaction to 10 Int. Units of P.P.D. injected intradermally in the forearm for the pre-vaccination Mantoux test. There was considerable brawny swelling of the arm and a haemorrhagic blister occurred at the site of the injection. A shallow ulcer formed of about ½" diameter which slowly healed in the next few weeks, leaving a scar." Tuberculin tests on 3,629 children vaccinated the previous year suggests that 341 or 9·4 per cent. had reverted to Mantoux negative. This feature is particularly emphasised in three divisions where the percentage of reversions to negative were 38·8 (Rotherham, No. 31 Division), 30·8 (Rothwell, No 16 Division) and 14·2 (Goole, No. 10 Division). These abnormal results throw some doubt on the efficacy of the accepted technique for Mantoux testing; recent investigations have pointed to the possibility of a positive reaction appearing later than had been previously expected, and adjustments are being made in the procedure so that this possibility is not overlooked.

The following table summarises the work undertaken during the year.

ACCEPTANCES.

No. of 13-year-old children offered tuberculin testing and vaccination if necessary ..		16,828
No. found to have been vaccinated previously		42
No. of acceptances		10,437
Percentage of acceptances		62·2

PRE-VACCINATION TUBERCULIN TEST.

No. of children tested		9,936
Result of test:		
Positive	3,026	
Negative	6,748	
Not ascertained	162	
	Total	9,936
Percentage positive		31·0

VACCINATION.

No. vaccinated	6,667

TUBERCULIN TEST TWELVE MONTHS AFTER VACCINATION.

No. tuberculin tested after 12 months		3,693
Result of test:		
Positive	3,268	
Negative	341	
Not ascertained	84	
	Total	3,693

In addition, records were received relating to 12 children normally resident in the County whose vaccination had been undertaken by arrangements made by neighbouring authorities.

Mass Radiography.—Seventy-five thousand two hundred and fifty-six persons from the Administrative County were examined by the mass radiography service (39,853 by units of the Leeds Regional Hospital Board and 35,403 by units of the Sheffield Regional Hospital Board). Details are not available of the results of two surveys undertaken in the Doncaster area at the close of the year and when due allowance is made for this fact, it will be seen that the 109 cases of active tuberculosis represented 0·15 per cent. of the total examined; there were 324 (0·46 per cent.) cases of non-active tuberculosis and 1,384 (1·96 per cent.) other non-tuberculous abnormalities of which 658 (47·5 per cent. of the total non-tuberculous abnormalities) were cases of pneumoconiosis. When separated into the two hospital regions, the percentage of cases of pneumoconiosis was 53·1 in the Sheffield Region and 34·0 in the Leeds Region. Details are given in the following table.

A.—Leeds Units

Survey undertaken at	No. Examined	Abnormalities Discovered			
		Tuberculosis		* Other	Total
		Active	Inactive		
Barnoldswick	1,935	3	12	14	29
Crosshills	871	2	6	7	15
Gargrave	270	—	1	1	2
Skipton	1,050	3	6	11	20
Bentham	596	1	4	6	11
Hellifield	201	—	1	1	2
Horton in Ribblesdale	159	—	1	5	6
Ingleton	211	—	3	2	5
Settle	577	—	3	4	7
Temperance Hall, Rawdon	1,802	2	8	15	25
Guiseley	604	—	3	5	8
Otley	1,787	3	4	6	13
Ilkley	810	3	3	4	10
Scalebor Park Hospital, Burley in Wharfedale	453	2	3	2	7
I.C.I., Harrogate	555	1	2	3	6
P.O. Savings Bank, Harrogate	1,453	1	4	5	10
Crown Hotel, Harrogate	1,723	5	6	11	22
Knaresborough	519	—	1	2	3
Boroughbridge	237	—	1	3	4
Sherburn in Elmet	152	4	2	15	21
Tadcaster	1,238				
Wetherby	780	—	2	4	6
Rawcliffe Hall Mental Hospital, nr. Goole	166	—	2	1	3
Snaith	242	1	—	5	6
Selby	1,674	3	4	8	15
Glasshoughton Colliery	1,188	2	13	47	62
Whitwood Colliery	559	1	13	28	42
Wheldale Colliery	608	—	4	43	47
Pontefract Community Centre	2,034	3	2	10	15
Horbury	312	—	—	1	1
Cleckheaton	672	1	2	6	9
Gomersal	228	—	1	—	1
Liversedge	633	—	4	4	8
J. Blakeborough & Sons, Brighouse	823	4	2	7	13
T. F. Firth & Sons, Bailiff Bridge	678	2	3	13	18
St. John's Ambulance Hall, Brighouse	941	5	6	6	17
Sowerby Bridge	1,182	3	2	9	14
Mytholmroyd	1,404	2	9	10	21
Todmorden	2,105	2	8	17	27
David Brown Industries, Scholes	244	—	2	1	3
Drill Hall, Thongsbridge	1,924	2	5	14	21
Storthes Hall Hospital, Kirkburton	2,557	15	54	34	103
Hemsworth	1,696	—	4	13	17
Total	39,853	76	216	403	695

B.—Sheffield Units

Survey undertaken at	No. Examined	Abnormalities Discovered			
		Tuberculosis		*Other	Total
		Active	Inactive		
Penistone	1,529	3	4	26	33
Darton	723	2	5	25	32
Mapplewell	982	—	3	41	44
Wombwell	4,942	6	14	241	261
Worsbrough Bridge	1,011	—	4	64	68
Percy Jackson Grammar School, Adwick le Street	716	1	1	3	5
Miners' Welfare Hall, Woodlands	2,526	1	5	94	100
Miners' Welfare Hall, Carcroft	1,655	2	7	51	60
The Pavilion, Bentley	3,227	2	9	110	121
Pilkington's, Kirk Sandall ..	1,703	—	7	28	35
Rockware Glass, Kirk Sandall..	607	3	3	13	19
Public Session, Kirk Sandall ..	182	—	—	4	4
Rossington	1,883	1	9	54	64
Askern	3,016	No details available			
Armthorpe	1,791	No details available			
Miners' Welfare, Stainforth ..	2,081	2	13	64	79
Miners' Welfare, Moorends ..	1,725	5	12	55	72
Thorne Grammar School ..	532	—	—	3	3
Council Offices, Thorne ..	1,005	1	5	11	17
Thurcroft	1,380	2	5	45	52
Maltby	1,642	2	1	45	48
D. Byford & Co., Maltby ..	545	—	1	4	5
Total	35,403	33	108	981	1,122
Total for the County Area ..	75,256	109	324	1,384	1,817

*Details of the 1,384 'Other' abnormalities are as follows:—

	Leeds Area.	Sheffield Area.
1. Abnormalities of the bony thorax and soft tissues—congenital ..	21	6
2. Abnormalities of the bony thorax and soft tissues—acquired ..	10	4
3. Tumours of the bony thorax: primary and secondary	—	—
4. Congenital malformation of the lungs	3	—
5. Bacterial and virus infection of the lungs	28	24
6. Other infections of the lungs	5	—
7. Bronchiectasis	48	43
8. Honeycomb lung	1	—
9. Emphysema	11	32
10. Pulmonary fibrosis—non-tuberculous	30	98
11. Pneumoconiosis	137	521
12. Spontaneous pneumothorax	3	2
13. Benign tumours of the lungs and mediastinum	8	1
14. Carcinoma of the lung and mediastinum	4	9
15. Metastases in the lung and mediastinum	1	1
16. Enlarged mediastinal and bronchial glands—non-tuberculous ..	1	1
17. Sarcoidosis and collaginous diseases	4	3
18. Pleural thickening or calcification—non-tuberculous	18	25
19. Abnormalities of the diaphragm and oesophagus—congenital and acquired	8	22
20. Congenital abnormalities of heart and vessels	12	3
21 Acquired abnormalities of heart and vessels	29	181
22. Miscellaneous	1	5
23. Enquiries not completed	20	—
	403	981

Care and After-Care.—Divisional Medical Officers have referred to the local impact of this work and to the close co-operation with the many agencies, statutory and voluntary, which are associated in its detailed application.

Six patients whose condition did not permit of their return to normal competitive employment were admitted to the training settlements at Papworth (2) and Sherwood (4). Eight were discharged

for various reasons and at the end of the year, there were eleven in residence at Papworth (4) and Sherwood (7). In addition there is a number who have been successfully absorbed in the village settlement at Papworth and for whom the County Council no longer has any direct responsibility.

Extra nourishment, consisting of up to two pints of milk daily, continues to be available for domiciliary patients suffering from active tuberculosis; 8,851 grants were approved including those to 1,384 patients at the end of the year.

Domiciliary open-air shelters, beds, mattresses and bedding are provided to facilitate the segregation of the tuberculous patient who continues to reside at home.

Grants from the West Riding Distress Fund have been made, occasionally for clothing, but more generally for the payment of travelling expenses to enable family relatives to visit the tuberculous patient whilst undergoing hospital treatment.

During the year, the Leeds Association for the Care of Consumptives agreed to extend its activities into that part of the Administrative County area served by the Leeds Chest Clinic, and so increased the number of Tuberculosis After-Care Committees to ten serving, wholly or in part, sixteen of the twenty-eight divisions in the County. The function of these Committees is to endeavour to ease the problems, financial or otherwise, with which the tuberculous patient and his family have to contend. Their membership includes lay and professional members representative of all branches of the health service and of other statutory and voluntary organisations as well as interested individuals; in this way, they are able to advise patients needing help of the facilities available from statutory sources and ensure that the Committees' resources are reserved for help only to those patients and their families who are outside the scope of help provided by the statutory bodies. The type of help given is varied, ranging from assistance in the provision of clothing, holidays, extra nourishment, etc. for individuals to large scale outings and Christmas parties for groups. It is perhaps the personal interest which the Committees have in patients, helping them to overcome employment difficulties and social problems, which proves to be of the greatest value in the work of care and rehabilitation. Grants amounting to £820 have been paid by the County Council to the Committees to support their continued activities.

Liaison with the Hospital Service

The patient admitted to hospital is no longer regarded solely as a condition to be treated; he is recognised as a casualty of society, coming from and returning to the world outside the hospital wards. Attention must be directed to his needs while awaiting admission, to those of his family during hospitilisation, and to his after-care and rehabilitation, in its widest possible interpretation, on discharge. The care and after-care services of the Local Health Authority are designed to meet those needs and, equally important, the patient and all concerned with his care should be fully aware of the help which can be afforded. It is pleasing to record that these same services are now featured to a much greater extent in the medical and nursing training curricula. If then it is in the interests of the patient that his condition should be reviewed not only as a clinical entity but in relation to his social environment, it necessarily follows that there must exist the closest possible relationship between the hospital and domiciliary services. It is a constant aim, therefore, to make this relationship secure by negotiations to permit of a local health visitor having ready access to the hospital, to the wards, the patients, and the nursing and almoning staff, for it is in this way only that there can be any assurance that the peculiar needs of any patient have not been overlooked. Although this process has not developed as fully as is desired, it would be misleading to suggest that there is an absence of co-operation from those hospitals which do not accept our proposals. On the contrary, much has been achieved and the following summary serves to mark the progress which has been made.

Maternity.—In addition to the statutory notification of births, there is now a more generally adopted procedure of notifying either the Divisional Medical Officer or the individual midwife of impending early discharges from maternity hospital, thus ensuring continuity of care for both the mother and the baby.

Premature Babies.—There is an increasing tendency to co-operate with the Local Health Authority on the problems associated with the discharge home of a premature baby. Nowhere is this practice more marked than with the Leeds Maternity Hospital where there is regular attendance by a County health visitor to discuss the individual cases to ensure continuity of care and the follow-up of the progress of such infants.

School Children.—There has been an over-all acceptance of the principle of sending to the Divisional Medical Officer a copy of the letter sent to the general medical practitioner when a school child is discharged from hospital.

Tuberculosis.—In the peculiar position where the chest physician holds a joint appointment with the Hospital and Local Health Authorities, and where the tuberculosis health visitor has ready access to the chest clinic records, there is established the closest possible relationship between the two services.

Geriatrics.—Geriatricians have shown themselves to be particularly aware of the benefits of liaison with the Local Health Authority in problems associated with the admission, care and discharge of aged patients to and from chronic sick wards. Particular examples of this development are noted at Knaresborough and Pontefract.

Diabetics.—Reference is made on page 51 of this report to the new approach which has been made to the home care of the diabetic patient where the three parts of the National Health Service show a united approach to the problem.

General.—The foregoing are examples of specific groups where the peculiar needs demand co-operation between the two services. Similar needs of the general medical and surgical cases are not so readily demonstrated and it may be argued that the particular needs of individual patients are well met by the existence of cordial relationship between the hospital and local health authority without any formal relationship; the contrary view is that the less tangible needs can never be wholly evaluated without the intervention of a health visitor co-operating with the family doctor and having an intimate knowledge of the patient's environment.

Typical extracts from the reports of Divisional Medical Officers illustrate the progress and mark some of the problems.

Dr. M. Hunter, Skipton (No. 1) Division—

" Although the Divisional Medical Officer and his Senior Clerk undertake a certain amount of liaison work, chiefly by telephone, it is the Superintendent Health Visitor who performs most of the work in this field. She has a close liaison with the Bed Bureau Staff and the Almoners, and completes a form of particulars in respect of all patients recommended by their doctors for chronic sick accommodation. This, of course, entails visiting the patients at home, and during 1956 she paid 128 such visits. To some extent this is related to duties under the Home Help Service. In addition, the Superintendent Health Visitor does occasional ward rounds with the consultant physician at Raikeswood Hospital, Skipton. This assistance is much appreciated by the hospital authorities, but more could be given if more staff and time were available, and there is undoubtedly scope for further developments in this field. I refer particularly to the fact that almoners do not have cars, and in a rural and scattered urban district it is difficult for them to do domiciliary visits in connection with either the admission or discharge of patients. Hospitals outside our group and to which cases are referred for more specialised investigation and treatment have almoners who contact the department when necessary."

Dr. D. D. Payne, Harrogate (No. 8) Division—

" One health visitor is engaged almost full-time on this work and attends the Knaresborough Hospital daily from 9 to 11 a.m., approximately and again in the afternoon. She visits aged patients in Divisions 8 and 9 at the request of general practitioners and arranges for them to be admitted to the geriatric wards in order of priority. She accompanies the geriatrician on his weekly round, supplies him with background reports, and makes suitable arrangements for those patients who are fit for discharge. She closely co-operates with the district health visitors who take over the after-care of those patients who return home. One service which is increasingly popular with patients and their relatives and which also results in a saving of hospital beds is the temporary admission of aged patients while their relatives have a holiday. This health visitor also helps patients in geriatric and chronic sick wards with any social problems which arise.

A health visitor and a medical officer from the divisional office staff attend the Paediatric Out-patients' session at the Harrogate General Hospital one afternoon per week and supply background information on the patients where needed and help in any medical social problems that may arise. Copies of the Paediatrician's letters to practitioners are routinely sent to the Divisional Medical Officer.

When patients are discharged from the Maternity Unit of the Harrogate General Hospital and also from Carlton Lodge Maternity Home, notification is sent to the Divisional Medical Officer. This was a new introduction started in 1956.

The tuberculosis health visitor visits her patients in Scotton Banks Hospital, supplies the Medical Superintendent with background reports and arranges for examination of contacts where this has not already been done. She arranges the after-care of those discharged home.

From time to time, at the request of consultants, almoners or nursing staff, health visitors of whom there are 15, may pay home visits to patients requiring discharge from the Royal Bath Hospital, The Yorkshire Home and the White Hart Hospital. These visits are for after-care, to supply medical social information or to help with home problems. Occasionally, on request, patients may be visited direct in these hospitals."

Dr. J. M. Paterson, Castleford (No. 11) Division:—

" A health visitor is attached to the Castleford, Normanton and District Hospital which, in the main, deals with a variety of surgical conditions. In view of the shortage of surgical beds and the overriding demand that patients be sent as soon as possible after operation to annexes, which are in every case situated outside this Divisional area, the amount of follow-up work that can be done is extremely limited. It would be most helpful indeed if the health visitor concerned could also attend the annexe hospital to which these patients go and follow up those cases which come from this Divisional area. This worker has the full co-operation of the local hospital nursing staff and not infrequently is asked to contact patients who have defaulted and/or stopped attending for treatment at the Out-patients' Department.

There is a high degree of co-operation existing between the Health Visitor and the Matron of the Castleford Maternity Home, and although the type of work done is not productive of spectacular results, we can rest assured that a good job of work is being done. In the late ante-natal and early post-natal stages in a number of instances valuable relevant data were made available by the health visitors to the Matron, and conversely, on discharge, the district midwives or health visitors made aware of matters vitally concerning the mother or infant whilst in the Maternity Home. It would be desirable that the same liaison should exist with the Maternity Homes and Hospitals outside this Divisional area."

Dr. J. F. Fraser, Pontefract (No. 12) Division—

" A daily visit is made to the Pontefract General Infirmary by three Pontefract health visitors on a rota system to obtain details of the discharges and particularly the patients requiring after-care. The time taken on this work is approximately 2½ hours per week.

One health visitor works about 60 per cent. of her time on geriatric work at the Headlands Hospital, Pontefract. She undertakes all of this work for the whole Division. I think a much more satisfactory arrangement would be for each health visitor to be responsible for geriatric visiting in her own area. She usually knows all the family history and whether there are any relatives to help. This advantage, in my opinion, far outweighs any criticism there might be about the possibility of lack of uniformity of assessment if all health visitors do the work."

Dr. A. L. Taylor, Rothwell (No. 16) Division—

" Our relationships with the hospitals in the area are happy and no friction has arisen. As a general comment, however, it is fair to say that whilst information is readily forthcoming when the hospital requires the Local Health Authority's services in respect of patients about to be discharged, considerably less satisfactory results are obtained when we ourselves require information in respect of specific patients. This, no doubt, is due to the frequent changes of junior hospital staffs. Liaison with the geriatric units is extremely good and contacts are very helpful."

Dr. F. Appleton, Brighouse (No. 18) Division—

" The tuberculosis health visitor regularly visits the Sanatorium at Northowram, where most of our cases go. These visits are made every two months on the average. She spends there usually one afternoon but she also visits from time to time when any particular problem arises. She does much to re-assure the patients and their relatives and has helped to clear misunderstandings which necessarily arise when a long illness causes a long separation. Patients often require help and advice in making application for National Assistance, and the health visitor not only helps them to complete this but often undertakes their delivery. Advice is given about work that will be available when they return home. She is also able to form an idea of any diversional therapy being carried out in the hospital, so that it can be continued outside. Visiting patients inside does help when seeing the same patients outside.

The almoners of all the various hospitals communicate regularly with us. This is sometimes done personally with the health visitors, district nurses and midwives, but usually directly with this office as they are more certain of our telephone being answered. During 1956, more than 250 such communications with the various hospitals took place."

Dr. D. J. Cusiter, Wath (No. 26) Division—

" A health visitor attends once monthly at the Wath Wood Hospital and spends 2½ to 3 hours at the hospital. A request for a ' Home Conditions ' report is sent in respect of each new patient to the Divisional Medical Officer of the area where the patient lives. The health visitor interviews each new patient, discussing problems, giving advice and, if necessary, calling on the help of the Divisional Health Office staff.

Liaison exists with all hospitals in neighbouring areas through liaison health visitors in other divisions and with almoners of the hospitals concerned. Much work is carried out by all health visitors in order to provide background reports of patients admitted to hospital. Special reports are submitted in respect of all patients awaiting admission to the geriatric unit at Moorgate General Hospital, Rotherham. After-care is given in many cases on discharge."

Dr. J. M. Watt, Rotherham (No. 31) Division—

" Elderly hospital patients benefit most from the liaison visits by health visitors. When they are discharged from hospital, home nursing and home help services are provided and they also receive supervisory visits from the health visitors. Convalescent elderly patients have considerable help given to them by contact with the National Assistance officers, who provide extra bedding, clothing and pensions, which are frequently required for elderly people returning home after serious illnesses. Children under five years of age are the second most important group of cases. The health visitors give special attention to children from indifferent homes who have been involved in home accidents and give instructions to the parents on home safety. The third group, who particularly benefit, are unmarried mothers contacted at hospital ante-natal clinics. The arrangement of hostel accommodation at the County Council's expense is an important provision for these patients.

Better contact has been made with the Jessop Hospital and the Children's Hospital, Sheffield, through the hospital almoners. Particular care has been given for the convalescent gynaecological cases when they have been single women living alone. More reports have been furnished to the Children's Hospital upon home circumstances of patients for use by the medical staff."

Recuperative Home Treatment

Four hundred and fifty-seven applications for recuperative home treatment were received during the year. There were seventy-eight (15 per cent.) cancellations, and of the remainder three hundred and fifty-nine, 80 men, 278 women (24 with children) and one child were admitted to one or other of the undermentioned homes. 20 were on the waiting list at the end of the year.

Armitage House, Worthing; Binswood Short Stay Rest Home, Didsbury, Manchester; Blackburn and District Convalescent Home, St. Annes-on-Sea; Boarbank Hall, Grange-over-Sands; Brentwood Recuperative Centre, Marple, Cheshire; " Claremont " Convalescent Home, Matlock; Craig Convalescent Home for Children, Bare, Morecambe; Hunstanton Convalescent Home, Hunstanton, Norfolk; Metcalfe-Smith House, Harrogate; N.A.P.T. ' Spero ' Holiday Scheme; N.E.C.F.S. Convalescent Home, Grange over Sands; Semon Convalescents' Home, Ilkley; Shoreston Hall, Seahouses, Northumberland; Silver Jubilee Home, Heysham; Spofforth Hall, Spofforth; Valda Convalescent Home, Bridlington; West Hill Convalescent Home, Southport.

The Valda Convalescent Home, Bridlington, was visited by a special Sub-Committee in September, following which it was decided that similar visits should be made to other recuperative homes where substantial numbers of patients are sent for recuperation. It was also decided that recuperative homes are to be inspected by the County Medical Officer before being approved as suitable for the admission of County patients.

Provision of Nursing Equipment in the Home

During the year, 12,912 items of nursing equipment were issued to patients being nursed in their own homes; many were for short periods so that the items in question were re-issued a number of times whilst others continued on loan throughout the year. The equipment ranged from bed linen, bed pans

and urinals to special beds and mattresses, walking aids and hydraulic hoists, and their disposition at the end of the year was as follows:—

Item	*No. on loan*	*No. available for issue*	*Total*	*No. of issues during the year*
Bedding: blankets, sheets, pillows, and cases —pieces	2,076	165	2,241	2,164
Bed blocks	13	57	70	13
Bed cradles	99	86	185	203
Bed pans: enamel, porcelain, rubber and stainless steel	720	596	1,316	2,765
Bed rests	384	283	667	1,180
Bedsteads: hospital and special and with self-lifting poles	177	7	184	203
Bed tables	—	15	15	1
Blankets, electric	—	1	1	—
Breast pumps	—	9	9	1
Chairs, relaxing	4	—	4	6
Chairs, high rest	4	—	4	5
Chairs, ' Amesbury ', play	2	—	2	2
Chairs, stairway, carrying	—	1	1	—
Commodes, chair and other	97	2	99	144
Cushions, air and latex foam	48	4	52	123
Feeding cups	8	27	35	8
Fracture boards	19	2	21	19
Hot water bottles	24	102	126	26
Hydraulic hoists	2	—	2	2
Inhalers	1	9	10	1
Lifting frame	2	—	2	2
Mattresses: air, biscuit, hair, latex foam and water	273	30	303	333
Open-air shelters	15	12	27	18
Pressure rings: air and latex foam	494	682	1,176	1,695
Rubber sheets	768	551	1,319	2,148
Sputum mugs	33	113	146	43
Steam kettles	1	16	17	4
Urinals, male and female	441	728	1,169	1,296
Walking aids: ' Bonaped,' crutches, tripod, walking sticks	63	84	147	81
Wheel chairs: bath, folding, junior, self-propelled, spinal, stairway, etc.	209	62	271	426
TOTAL	5,977	3,644	9,621	12,912

Mental Health

During 1956 Care and After-Care was provided by the Mental Health Social Workers for 509 mentally ill persons, involving 2,598 visits in respect of such persons, the majority of whom had been discharged from Mental Hospitals, Out-patient Clinics or the Armed Forces. In a few of these cases the Teachers of the Mentally Handicapped visited and gave instruction in occupations suitable to their needs. In a minority of cases care and guidance were provided with the object of avoiding admission to Mental Hospitals with the consequent break of the rhythm of the lives of the persons concerned, some of whom were able to receive the treatment required at Out-patient Clinics. There were also 266 persons (mostly old people), with respect to whom the Duly Authorised Officers were consulted by the family general practitioners or relatives and in these cases steps were taken to provide the necessary care required, some being admitted to chronic sick Hospitals and others to Part III accommodation under the National Assistance Act. In other cases arrangements were made for Home Helps to be provided; Health Visitors and Social Workers undertook regular visits and relatives were persuaded to provide care or the patients were introduced to Old Folks Clubs and Associations with the result that many were able to overcome periods of depression and self neglect. Generally these old people have gradually withdrawn from their social contacts making early ascertainment very difficult and it is felt that if relatives or neighbours and friends would inform the Divisional Medical Officer or any of his Officers on noticing this process of withdrawal from the community earlier assessment of the particular needs of the person concerned would be possible.

Short Stay Care.—During 1956 short stay care was provided in National Health Service Hospitals for 186 mentally defective persons (126 children and 60 adults) under the provisions of Circular 5/52 and one child was admitted to short stay accommodation in a private home at the expense of the County

Council. Short stay provision has proved of great advantage to both patients and parents, particularly where the mother is about to be confined or is ill and has to be admitted to Hospital or where parents have not, in some cases for many years, been able to have a holiday. In such cases, every effort is made to obtain short stay care for the patient.

Venereal Diseases

It is gratifying to record that the number of new cases of all forms of venereal disease diagnosed at Special Treatment Centres attended by patients from the Administrative County declined during 1956.

There has been a steady fall in the total number of new cases since the year after the end of World War II when the number was 3,722, whereas in the year under review the figure was 1,397.

In comparison with the pre-war year of 1938, syphilis and gonorrhoea together have declined by 742. On the other hand, other conditions have increased by 640. The result is that the total number of new patients has fallen by only 102 from 1,499 in 1938 to 1,397 in 1956.

The reasons for the increase in " other conditions " may be found in the following:—

(1) A marked increase in the incidence of non-gonococcal urethritis in males and non-specific vaginitis and cervicitis in females.

(2) An increase in the number of patients attending for observation following exposure to possible venereal infection.

(3) An increase in the number of patients suffering from minor genito-urinary ailments.

(4) A great improvement in the tracing of contacts of known cases of venereal disease and the resultant examination of more suspected cases.

A comparison of the number of new cases for the past 19 years is provided in Table A:—

New Cases (compared with previous years). Table A.

Year	Syphilis	Gonorrhoea	Total of new cases of Syphilis and Gonorrhoea	Other Conditions	Total of new Patients
1938	346	650	996	503	1,499
1939	403	678	1,081	593	1,674
1940	299	499	798	497	1,295
1941	331	552	883	587	1,470
1942	423	479	902	735	1,637
1943	487	654	1,141	1,344	2,485
1944	413	560	973	1,383	2,356
1945	473	767	1,240	1,419	2,659
1946	723	1,140	1,863	1,859	3,722
1947	573	729	1,302	1,511	2,813
1948	463	550	1,013	1,403	2,416
1949	435	383	818	1,360	2,178
1950	357	304	661	1,447	2,108
1951	247	171	418	1,212	1,630
1952	219	211	430	1,275	1,705
1953	214	182	396	1,228	1,624
1954	178	152	330	1,189	1,519
1955	175	135	310	1,168	1,478
1956	155	99	254	1,143	1,397

The figures given in Table B are of considerable significance as they give statistical evidence of the success of the contact tracing work and other measures to control the incidence of infectious syphilis since 1949.

It is pleasing to record that for the second time in three years there were no cases of congenital syphilis under 1 year of age.

Table B.

Year	Early Acquired Syphilis	Congenital Syphilis under 1 year	Total Early Syphilis
1949	158	7	165
1950	76	4	80
1951	58	4	62
1952	19	1	20
1953	9	1	10
1954	7	-	7
1955	6	1	7
1956	9	-	9

Table C shows the numbers of new cases diagnosed at Special Treatment Centres for each quarter of 1955 and 1956.

New Cases (Quarterly and stage of disease). Table C.

Quarter Ended	Acquired Syphilis				Congenital Syphilis				Gonorrhoea		Other Conditions	
	Early		Late		Under 1 year		Over 1 year					
	1955	1956	1955	1956	1955	1956	1955	1956	1955	1956	1955	1956
31st March	1	2	36	31	1	—	10	5	31	18	290	263
30th June	3	1	24	28	—	—	9	7	31	29	274	292
30th September ..	2	1	35	30	—	—	7	6	40	33	318	297
31st December ..	—	5	33	31	—	—	14	8	33	19	286	291
	6	9	128	120	1	—	40	26	135	99	1,168	1,143

The addresses of the Special Treatment Centres at which new patients from the Administrative County attended during 1956 and the number of cases of each disease diagnosed are given in Table D. On aggregate over the whole Administrative County the ratio of new cases of all types of syphilis to gonorrhoea during the year was approximately 3 : 2.

New Cases (Treatment Centres). Table D.

Special Treatment Centre	Syphilis	Gonorrhoea	Other Conditions	Total
Barnsley Clinic, Queen's Road	11	9	82	102
Bradford St. Luke's Hospital	11	6	84	101
Burnley Victoria Hospital	3	—	6	9
Dewsbury General Hospital	5	11	59	75
Doncaster Royal Infirmary	18	21	214	253
Goole Bartholomew Hospital	1	1	8	10
Halifax Royal Infirmary	12	9	76	97
Harrogate General Hospital	12	3	41	56
Huddersfield Royal Infirmary	8	3	71	82
Keighley Victoria Hospital	9	—	57	66
Leeds General Infirmary	18	17	134	169
Oldham Boundary Park General Hospital	—	—	9	9
Rotherham Moorgate General Hospital ..	14	3	99	116
Sheffield Jessop Hospital	—	—	2	2
Sheffield Royal Hospital	1	1	12	14
Sheffield Royal Infirmary	4	—	8	12
Sheffield City General Hospital	—	—	—	—
Wakefield Clayton Hospital	28	12	155	195
Westmorland County Hospital	—	1	3	4
York County Hospital	—	2	23	25
	155	99	1,143	1,397

V.D. Social Work.—The staff consists of four whole-time Social Workers who are all state registered nurses with Health Visitors Certificates. The work comes under the immediate direction of a Consultant Venereologist who acts as adviser in venereal diseases to the County Council and is responsible to the County Medical Officer for V.D. prevention and after-care in the Administrative County. The clerical and statistical work is in the hands of a confidential clerk typist.

The County has been divided into four areas and each V.D. Social Worker traces the contacts, follows up the defaulters and is on the staff of one or more of the Special Treatment Centres in her area, in order to carry out the clinic social work. Three of the areas are coterminous with the County Boroughs of Dewsbury, Doncaster, Halifax and Wakefield and by arrangement three of the Social Workers undertake similar duties in these County Boroughs. This scheme operates smoothly and is a much better one for both patients and medical staff at Special Treatment Centres, than having two social workers at each centre—one for County Borough patients and one for Administrative County patients.

Every effort is made to bring under examination any person who may be infected with a venereal disease. Information about possible cases is received from many sources including:—

(a) New Patients with Venereal Disease.—The Social Workers at Special Treatment Centres interview new patients found to be suffering from venereal infection and obtain information regarding contacts and other persons who may be infected. The latter are asked to attend a Special Treatment Centre either on the request of the patient or, if this is ineffective or not possible, by a personal private visit by the Social Worker (Contact Tracing Table E). In this important and responsible work every care is taken to ensure that the strictest confidence is observed, and much tact, persuasion and perseverance on the part of the Social Worker is necessary.

Contact Tracing. Table E.

Total No. of contacts reported ..	72				
Located and examined		62			
Not infected			50		
Infected			12		
Already under treatment ..				—	
Brought under treatment				12	
Syphilis					8
Gonorrhoca ..					4
Located		7			
Not examined			5		
Transferred to other authority ..			2		
Not located		3			
Insufficient information ..			2		
Unable to locate			1		

(b) Ante-natal Cases with Positive Blood Tests.—Pathologists working in the region send to the Consultant Venereologist the name and address of any doctor (but not the name of the patient) who has sent in for testing a specimen of blood from an ante-natal patient giving positive tests for syphilis.

The Consultant Venereologist through the V.D. Social Worker offers assistance to the doctor in arranging the examination and if necessary the treatment of the patient and her contacts. In some cases, by this means whole families are examined.

Details of the ante-natal cases and their contacts which were investigated by the V.D. Social Workers are given in Table F:—

Ante-Natal Cases. Table F.

Patients						Contacts of Patients		
No. of positive reports on specimens from ante-natal clinics	No. investigated by Social Workers	No. further action necessary	No. referred direct to S.T.C.	No. found to have syphilis	No. found not to be infected	No. of contacts examined	No. found to be infected	No. found not to be infected
31	26	10	7	18	1	27	4	23

Of the 27 contacts examined 3 were adults with late syphilis and 1 a child of 5 years with congenital syphilis.

As a part of the socio-medical work at the clinics the V.D. Social Workers are concerned also with the follow up of patients who have ceased to attend before completion of treatment or tests of cure.

When this occurs the Social Worker, as a first step, may write to the defaulting patient inviting re-attendance. If this is not successful she will try and see the person privately (see Table G) in order to ascertain the reason for non-attendance, to explain to him or her the importance of complete cure and to help to remove obstacles to re-attendance.

Defaulters. Table G.

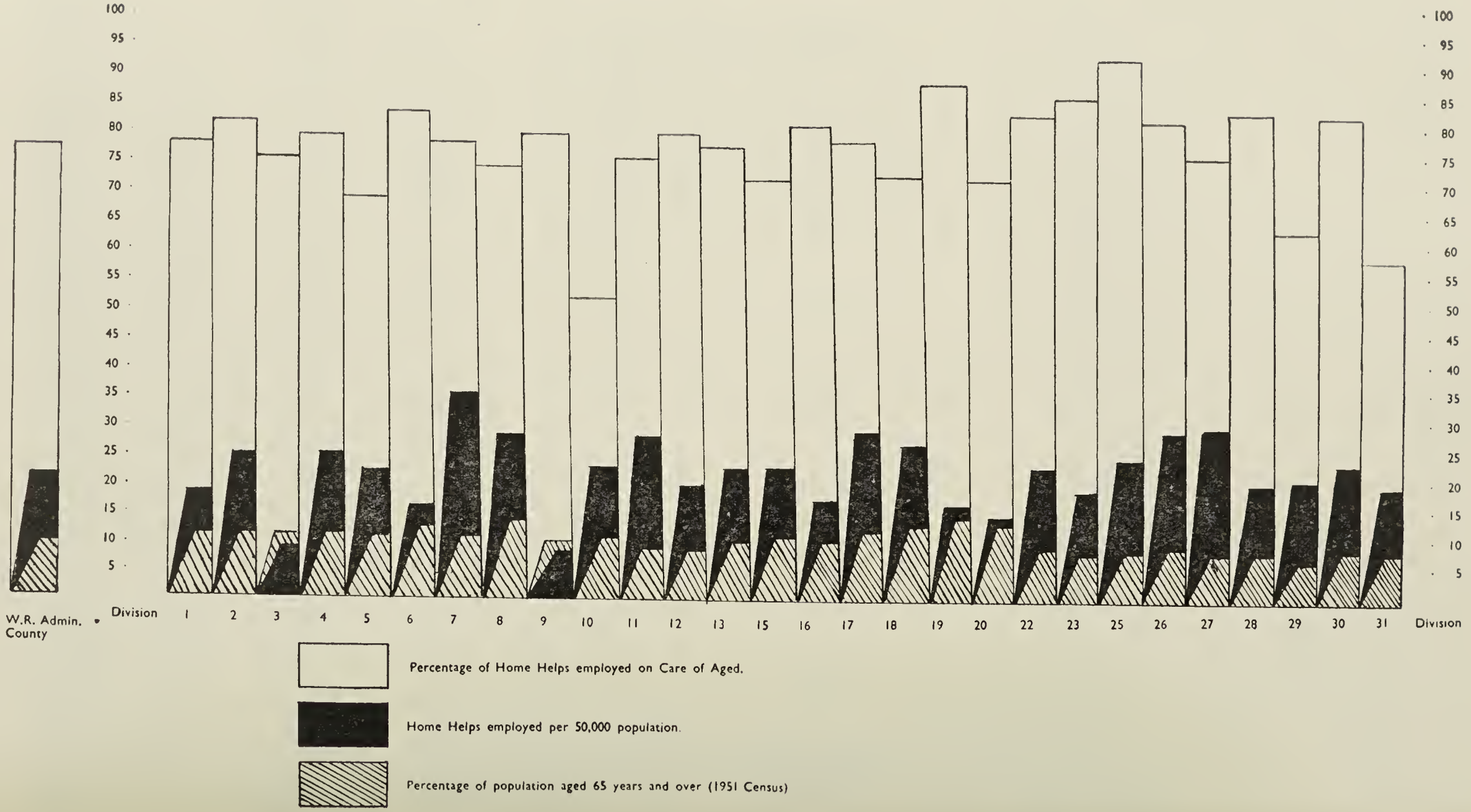
Total number of defaulters	Returned to clinic after visiting	Failed to return	Removed, unable to locate	Transferred	Number of ineffective visits	Number of re-visits
359	222	70	16	51	456	829

No figures are available of the number of patients seen in the clinics, but during the year there were 735 interviews with doctors and 1,470 miscellaneous interviews in addition to the work referred to above.

HOME HELPS

> "*29.—(1) A local health authority may make such arrangements as the Minister may approve for providing domestic help for households where such help is required owing to the presence of any person who is ill, lying-in, an expectant mother, mentally defective, aged, or a child not over compulsory school age within the meaning of the Education Act, 1944.*"

In the financial year ended 31st March, 1956, payments for home help service totalled £16,292 representing some 6·5 per cent. of the total expenditure on the service, £249,087. During the same period, more than 83 per cent. of the service was devoted to the care of the chronic sick, aged and infirm and those suffering from tuberculosis. These factors mark the development which has been seen to be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W.R. Admin. County
Division
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Division
Percentage of Home Helps employed on Care of Aged.
Home Helps employed per 50,000 population.
Percentage of population aged 65 years and over (1951 Census)

occurring during the past years; it gives cause for reflection on the philosophy of the service and how far it has departed from the original intention when " the Minister feels that the discharge of the Local Health Authorities' duties, particularly those relating to the care of mothers and young children, domiciliary midwifery, home nursing, and the care and after-care of persons suffering from illness or of mental defectives will be seriously hampered without an adequate and efficient domestic help service " (Circular 118/47). Since the introduction of the Act, however, there has been a reduction in all but one class of persons served—the aged and chronic sick. While readily acknowledging the valued contribution the service is making towards the care of the aged, it is pertinent to enquire why it is not equally being used by those classes of patient who were originally of prior consideration. The answer may be in the cost of the service, the standard charge being 3s. 5d. per hour or £7 10s. 4d. for a 44-hour week; although the assessment scheme permits of a reduction or a remission of these charges in necessitous cases, there must be many applicants whose income warrants a partial or full assessment, but whose family expenditure is so pre-determined as to make them unwilling, if not unable, to accept the additional charge during periods of acute illness or domiciliary confinement. The answer to the problem is not clear but it is becoming increasingly obvious that any greater cost which may arise from the Authority's desire to improve the wage rates or terms and conditions of service of the home helps, to institute training courses, or to appoint Supervisors, will be followed by a further diminution of service to those applicants who are deemed able to pay. Alternative methods of seeking to ameliorate this difficulty might be either to have some regard to the contribution from general taxation and so adjust the standard charge to below that of the actual cost, or to adjust the assessment scheme to provide for a rate per hour assessment so that payment became related to the time spent by the home help in the household; in this latter case, the amount of help could then be limited to that which the householder deemed himself to be able to pay.

Another feature has been the use of the home help in substitution of other services; the urgency of hospitalisation may be reduced by the provision of a home help in augmentation of home nursing; institutional care of the aged may be similarly delayed or avoided, and the provision of a home help may remove the need for taking children into care; in this latter event, the service is being of positive help in retaining the family as a unit. It may be regretted that these measures cannot be more universally applied, but a stage is rapidly reached when the cost of the domiciliary services begins to outrun that of institutional care. Furthermore, the home help can be provided, with very limited exceptions, only on application and there are those who are not prepared to complete the necessary forms with the accompanying acceptance of some financial responsibility.

The close relationship between the Home Help Service and the problems associated with the care of the aged is aptly illustrated in the report of Dr. J. M. Watt, Divisional Medical Officer of the Rotherham (No. 31) Division:—

" The two Assistant Health Visitors in Division 31 engaged on Home Help supervision devoted a great deal of their time to the care of sick and incapacitated elderly people. They were the means of obtaining personal clothing, bed-clothing, home appliances, surgical appliances and nursing equipment. As a result of action by the two health visitors, elderly people were supplied with:—

Spectacles	27
Dentures	2
Hearing Aid	1
Chiropody Treatment	3
Nursing Equipment	3
Wheelchairs	2
Radios	2
Fireguards	27
Bed	1
Bed-clothing	12
Personal clothing	5

Two of the more difficult cases dealt with by the health visitors in the Home Help Service were:—

1. An elderly woman, over 80 years of age, living alone in a four-roomed house. The windows were covered with old rags and brown paper and there were cobwebs in every room. The bed was stinking and verminous. The water-closet was not being used. Two home helps worked daily for a fortnight to clean the house thoroughly. A large quantity of old furniture and an accumulation of rubbish were thrown out. A new bedstead, bed-clothing and curtains were supplied. The elderly woman was given a complete change of all personal clothing and home nursing supervision was arranged. After a year's attention by the Home Help Service the elderly woman was carrying on successfully at home.

2. An elderly crippled woman, over 70 years of age, was living alone. She was only able to feed herself and wash her hands and face. A home help and a home nurse visited the home daily to attend to the patient's needs. The daily routine began with a visit from the home help in the early morning to open the house, light the fire and provide the patient with breakfast. The home help returned to prepare the midday and evening meals and made a final visit to lock up the house. The Sunday visits were paid by three home helps on a rota basis. House repairs were arranged by the Public Health Inspector, an allowance for bedding and personal clothing was paid through the National Assistance Officer and a radio set was provided by the Welfare Department. By these means, this severely crippled woman was able to continue to live at home for four years."

As was forecast last year, a further increase became necessary in the establishment which was raised from 700 to 800 whole-time home helps, or the equivalent in part-time workers, as from 1st October, 1956, giving an over-all authorised establishment of 725 for the year under review. The allocation to the divisions was 720 and the use of the service represented the whole-time employment of 688·1 home helps.

During the year, 10,549 cases received 1,574,424 hours help through the service as compared with 9,938 cases and 1,550,188 hours in 1955. The service provided for the aged and chronic sick represented 76·2 per cent. of the cases (1955-73 per cent.) and 83·7 per cent. of the total hours (1955—82 per cent.);

this group includes a small proportion of chronic sick patients under 65 years of age (7·3 per cent. of the total cases and 7·2 per cent. of the total hours worked). The statistical details are as follows:—

Number of home helps employed at 31st December:—

Whole-time by part-time workers	17
Part-time	1,742
TOTAL	1,759

Classification	No. of Cases				Total	
	1st Jan., 1956	New	Dis-continued	Remaining 31st Dec. 1956	No. of Cases	Hours employed
Maternity	63	1,392	1,403	52	1,455	109,395
Tuberculosis	60	72	63	69	132	30,196
Chronic sick, aged and infirm:—						
(a) aged 65 plus ..	4,411	2,866	2,378	4,899	7,277	1,203,679
(b) under 65	333	439	374	398	772	113,604
Other	294	619	634	279	913	117,550
Total	5,161	5,388	4,852	5,697	10,549	1,574,424

The graph on page 70 illustrates three of the major factors affecting the service.

MENTAL HEALTH

"51.—(1) Section twenty of this Act (which requires local health authorities to submit proposals to the Minister for carrying out their duties under certain provisions of Part III of this Act and to carry out those duties in accordance with the proposals) shall apply with respect to the duties of local health authorities under the Lunacy and Mental Treatment Acts, 1890 to 1930, and the Mental Deficiency Acts, 1913 to 1938."

Administration.—The detailed administration of the Mental Health Service of the County Council has been referred by the Local Health Authority to a Mental Health Sub-Committee consisting of 24 members which meets monthly.

The staff of the Mental Health Section of the County Health Department consists of:—

(*a*) *Medical.*

The County Medical Officer is responsible to the Mental Health Sub-Committee for the organisation and control of the Mental Health Service and he is responsible for the medical direction of the service.

The local medical administration of the Mental Health Service is undertaken by the whole-time Divisional Medical Officers in the 28 Divisions into which the County has been divided for the divisional administration of the preventive medical services. The Divisional Medical Officers and Assistant County Medical Officers approved for the purpose give certificates in accordance with the provisions of Sections 3 and 5 of the Mental Deficiency Act, 1913, and also undertake the statutory medical visitation of mentally defective persons under guardianship and complete Special Reports and Certificates in accordance with the requirements of Section 11(4) (b) of the Mental Deficiency Act, 1913.

(*b*) *Non-Medical.*

(i) Two Senior Clerks are approved by the County Council to act as Petitioning Officers. One of these officers holds the Diploma in Public Administration and the Extra-mural Certificate in Social Organisation of Leeds University.

(ii) There are 23 Duly Authorised Officers under the Lunacy and Mental Treatment Acts, most of whom have had many years' experience of the work and also perform welfare duties under the National Assistance Acts. In addition certain members of the male staff of the Divisional Welfare Offices have been trained to act as duly Authorised Officers in exceptional cases such as protracted absence of an Authorised Officer owing to sickness or during holiday periods.

(iii) Sixteen Mental Health Social Workers are employed in the Health Divisions, all of whom have had four to five months' training organised by the County Council prior to being allocated to their duties in the respective Medical Divisions. Three Social Workers attend Psychiatric Out-patient Clinics to assist the Psychiatrist with new patients, visits to patients' homes and relatives and acting as liaison officers between the Psychiatrists and other Local Health Authorities or the Authorised Officers.

(iv) There are three Supervisors of Occupation Centres, two of whom hold the Diploma of the National Association for Mental Health and the other has had many years' experience in School Departments of Hospitals. Additional staff at the three Occupation Centres consist of female Assistant Supervisors or Nursery Assistants.

(v) Twenty-one whole-time Teachers of the Mentally Handicapped and two part-time Teachers undertake teaching in the homes or in group classes and most of them have had some years' experience in teaching mental defectives and teaching in primary schools or evening institutes. In addition one teacher is at present attending the full time 12 months course of the National Association for Mental Health. There is an establishment for 24 Teachers of the Mentally Handicapped.

(vi) There are six established posts for Psychiatric Social Workers but no applications have been received from qualified persons to fill them.

The Consultant Psychiatrists in Lunacy or Mental Deficiency employed by the Regional Hospital Boards are most co-operative and always willing to give clinical opinions and advice on medication, either at out-patient clinics or at the appropriate Hospitals and by domiciliary visits.

West Riding patients are admitted to 8 different Mental Hospitals but there is no uniform method of co-operation with the Hospitals except that when specific information regarding a discharged patient is requested this is usually forthcoming. It is considered, however, that increased and closer co-operation will be necessary to ensure the continuity of care required in work of this nature.

Training of Staff.—The inability to obtain Psychiatric Social Workers is referred to above but every endeavour is made to fit the Mental Health Social Workers to carry out care and after-care of the mentally ill as well as of the mentally defective.

The County Council are anxious that the scope of the training provided should be increased and two Officers are at present attending an In-service Refresher Course promoted by the National Association for Mental Health (in conjunction with the University of Leeds) and it is hoped to second two other officers to a similar course in 1957/58. A course for new entrants to the services, as envisaged in the Report of the Mackintosh Committee, is very necessary. This Authority has endeavoured to provide training for new entrants on the lines given below but now that the establishment of Mental Health Social Workers is complete there is difficulty in providing the training for individual applicants to fill the occasional vacancies through resignations. Training, however, is still provided for new entrants, as far as possible, on the following lines:—

> One month at an Institution for mental defectives doing ward rounds with nurses, examining case papers and receiving lectures on mental deficiency, elementary psychology, etc., followed by one month at a Mental Hospital talking to patients, seeing and assisting with treatments, attendances at Out-patient Clinics and Occupational Therapy Department. Experience in the Child Guidance Service including attendance at Neurological Clinics and Child Guidance Centres. Training in the Mental Health Section of the County Health Department in the administrative side of the work, the statutory and voluntary Mental Health Services and visits to Occupation Centres and practical work with an experienced Social Worker.

The County Council have a scheme whereby the staffs of Occupation Centres and Teachers of the Mentally Handicapped are recommended for the 12 months' course of training provided by the National Association for Mental Health. Those accepted for the course are granted leave of absence for the period of the training and the County Council make a loan to students of 60 per cent. of the salary of a qualified Teacher of the Mentally Handicapped during the period of the course and also pay the course and examination fees. The loan is not repayable if the officer remains in service with the County Council for a period of not less than two years after the end of the course. As mentioned above, one of the Teachers is taking the present course of the Association.

There is close co-operation with all County Services to avoid overlapping, for example, where a mentally defective child is in the care of the Children's Department it is usual to arrange which Department shall undertake the major supervision and keep the other Department informed of the conditions and requirements. There is also very close co-operation with other statutory and voluntary services (Probation, Ministry of Labour and National Service, National Assistance Board, National Society for the Prevention of Cruelty to Children, Women's Voluntary Services, etc). In some Health Divisions frequent meetings are held at which all Social Welfare branches of the County Council are represented and all other statutory and voluntary Welfare Services are invited.

Lunacy and Mental Treatment Acts.—Action under the Lunacy and Mental Treatment Acts during 1956 was as follows, the figures for 1955 being given in brackets:—

> Lunacy Act, 1890, Patients admitted under Section 16, 408 (469); under Section 20, 322 (231); under Section 21, 82 (47); under Section 11, 8 (6).
>
> Mental Treatment Act, 1930, Assistance given in respect of patients admitted under Section 1, 353 (257); under Section 5, 11 (8).

The Duly Authorised Officers were consulted by general medical practitioners or relatives in 266 instances (191) where action under the Lunacy and Mental Treatment Acts was considered unnecessary.

The Medical Superintendents of the Mental Hospitals will arrange, at the request of the Duly Authorised Officers, domiciliary visits either by themselves or members of the medical staffs, and advise on the mental condition of individual patients and the action considered desirable.

The Psychiatric Out-patient Clinics and Specialist Services have proved a boon in providing early treatment in difficult cases. An additional Out-patient Clinic was provided during 1955 at Brighouse in premises provided by the County Council and at which the Mental Health Social Worker for the district attends and provides background and other information for the Psychiatrist. At the present time there are four such Psychiatric Clinics at which County Mental Health Social Workers assist and

this type of service is of great benefit to the Workers themselves in addition to being a valuable extension of the Mental Health Service.

Dr. F. Appleton, Divisional Medical Officer, and Dr. Vincent G. Crotty, Consultant Psychiatrist, report on the Brighouse Psychiatric Out-patient Clinic, as follows:—

Dr. F. Appleton (Divisional Medical Officer, Brighouse).

" Dr. E. Atkinson, the Assistant County Medical Officer, who has assisted Dr. Crotty, the Consultant Psychiatrist, at the Clinic, has gained a great deal from this association, and she has been able to see cases at the ordinary child welfare and school clinic sessions, many of whom it has not been found necessary to refer to the Child Guidance Service nor to the Psychiatrist. It is considered that we should proceed on these lines. The earlier we can see cases and prevent them from developing into frank mental ill-health, the more we can fulfil our duty as a preventive mental health service. The other part of a mental health service, that of helping people to attain positive mental health is, of course, a regular part of the duties of the Health Visitor and of the School Nurse, but it is contributed to by all the services, both of voluntary bodies and of local authorities, which improve the social circumstances of the home, and high on this list must appear the work of the Housing Committee of the local authority, the work of the school teachers, the National Assistance Board, and all the many voluntary clubs for old people. Employers, too, by making good working conditions, and the Welfare Officers of the larger industrial firms contribute their share to positive health.

There appears to be some improvement in the public attitude to mental illness. A person who is mentally ill for a short period has not always been regarded as convalescent and an object of sympathy rather than pity, and as a person who is comparable with someone recovering from a physical illness. As more and more people are admitted as voluntary patients, the attitude of the public does seem to be improving and it is becoming generally acknowledged that a patient recovering from mental illness requires rather more sympathy and help than someone who has been physically ill before they are capable of full restoration to complete health.

I believe that psychiatric clinics established within the preventive health service can play their part in inculcating within the public mind this new orientation to mental ill-health.

During 1956, there were 80 new cases attending our Psychiatric Clinic, and altogether 744 attendances were made. As the Clinic became longer established, more and more time was necessary, and towards the end of the year clinic sessions were extending from 2.30 p.m. to 9 p.m., and sometimes 10 p.m. Many of our patients were workers, and the evening session had become necessary, if patients were to be encouraged to continue with their work while still attending. This presented many advantages for patients who had been mentally ill, for it is a good thing to encourage patients who have been mentally ill to continue in the routine attendance at work and not to interrupt this whenever possible, and for this reason clinics have now been arranged alternate weeks for afternoon and evening sessions. This has meant a great deal more work for the Mental Health Social Worker, who has undertaken it cheerfully and courageously. She has felt great benefit from having behind her this Clinic and the firm backing and advice of Dr. Crotty.

No treatment has been carried out at the Clinic. All drugs have been ordered by the patient's own doctor, and when a patient has required E.C.T., or other treatment and is able to continue as an out-patient, this has been arranged at the Huddersfield Royal Infirmary. The X-ray examinations have been arranged through the Halifax Royal Infirmary.

The number of cases admitted to Hospital from the Clinic is fourteen, 13 of these being voluntary admissions. Only one was a certified case.

We have unfortunately received a considerable proportion of patients who had advanced mental illness. It was not originally intended that these cases would form any large proportion of the work of this Clinic, but it is inevitable that a certain number be of this character. There is no doubt that the patients have appreciated attending a building which is not primarily concerned with the treatment of disease.

All cases seen at the Clinic have been sent with the consent of the Family Doctor and with his co-operation."

Dr. Vincent G. Crotty (Consultant Psychiatrist, Storthes Hall Hospital, Kirkburton, near Huddersfield).

" During the past year the Clinic seems to have become firmly established. Referrals have been steady, and have in some cases been made by family doctors on the initiative of the patients themselves, due to their having heard of the Clinic and its accessibility from others. Psychiatric cases inevitably pile up when any serious attempt at Psychotherapy is made, with the result that we have now rather too many patients.

The majority of referrals consist of new cases. There has, however, been an increase in the number of follow-ups. Of children under school age we have had none this year, but we have had a number of school children. Those, needing play therapy, are at present seen by Dr. Atkinson, of the Divisional Health Department, since Dr. Leese, the County Child Psychiatrist, is already burdened sufficiently at Mirfield. In addition, Dr. Atkinson also deals with a number of the adults. I could wish that she saw more, but have been unable to work out a satisfactory method of distribution so far. (Any problems she has are discussed and this arrangement is working successfully.) The rapidity with which she has absorbed psychiatric methods of investigation and management makes her an increasingly useful member of the team.

Miss Wroe, the Mental Health Social Worker, continues to take histories of cases referred, to visit homes, employers etc., where indicated, and to deal with the laborious matter of the appointments.

Laboratory investigations are carried out by the County Laboratory, while the Radiologist at Halifax is most obliging where radiology is required.

The atmosphere of the Clinic continues to be pleasant, even when there is the strain of having to deal with too many people in too short a time.

Once again I must thank the Divisional Medical Officer, Dr. Appleton, for his constant helpfulness."

The following examples of patients dealt with during the year are of interest.

Follow-up visits in the case of a young married childless woman who had three periods of Mental Hospital treatment in little over twelve months revealed that during childhood and adolescence she lived with elderly grandparents and later found it difficult in her relationship with people of her own age. As she wished to take up some part-time work, she was enrolled in the Home Help Service and is a success working for elderly people particularly of the eccentric type.

A most difficult case dealt with was that of a mother with two young children—a case known to the Social Worker for the past two years. She suffers from obsessional neurosis, and though not certifiable is quite unable to cope with the management of home and children. There is a history of an unhappy childhood and an inadequate personality. She married to escape from uncongenial work. Her attitude to the marriage relationship is one of revulsion; she says she hates her husband and would leave him if it were possible and live her own life.

She visited a psychiatrist, though half-heartedly; she spends most of the day in bed and remains up until early hours attempting household jobs, though ineffectively. There was little preparation of meals. Frequent bickering between husband and wife resulted in a hopeless situation in which the mother became thin and haggard and the children unhappy and insecure.

The Children's Department, the N.S.P.C.C. and the Welfare Officer, were consulted but apparently no effective action could be taken.

Finally, the Social Worker applied for and obtained admission of the family to Brentwood Recuperative Centre. Although unable to make up her mind on the matter, the mother submitted willingly and with some relief to the Social Worker preparing the children, packing the luggage and acting as escort to the Centre. The family remained there for three months, and although little could be done for the mother's mental condition, all returned home physically improved and with a happier outlook. The mother particularly was reluctant to return home.

Finally, a home help, briefed in the case, attends the home to help build up something of a home life for the family.

An elderly lady complained of a hysterical pain which did not respond to treatment by drugs. The picture was of a lady who had been a manager all her life. She was able to help manage a business, do all her housework and still find time for visiting numerous friends. She had a good taste in clothes and liked to dress well. When she retired, she went to a somewhat isolated residence. The increasing age of her mother and the illness of her husband, the loss of the business and being unable to get out and about no doubt put her severely out of gear. It was significant that the pain was least when she was working, which suggested that tension played a considerable part in producing and maintaining the pain. Much was done for this lady by sympathetic listening, and there is no doubt that this has helped her to adapt herself to her new conditions. She has been helped, too, by being assisted in making new friends and is now able to face her many difficulties with considerable equanimity.

Difficulty is still experienced at many Hospitals in obtaining accommodation for patients suffering from senile dementia.

Mental Deficiency Acts 1913-38.—During 1956, 291 persons were reported to the Local Health Authority as alleged mentally defective persons. At the end of the year mental defect was not confirmed in 13 cases, action was not complete in 27 cases and 6 patients had been found not " subject to be dealt with." The remaining 245 were reported as follows:—By the Local Education Authority under Section 57 of the Education Act 1944: Sub-Section (3), 106 and Sub-Section (5), 88; by Police or Courts, 1; and from other sources, 50. These 245 mentally defective persons were dealt with as follows:—Placed under Statutory Supervision, 217; admitted to Hospitals, 28. Of the 6 patients who were found not " subject to be dealt with " 4 were placed under Voluntary Supervision and no action was necessary with regard to the remaining 2.

The total action taken during the year with regard to all patients shows that 165 patients were admitted to Institutions, as follows:—Placed under Section 3 of the Mental Deficiency Act, 1913, 89; Orders of Judicial Authorities obtained under Section 6 of the Mental Deficiency Act, 1913, 68; Orders made by Courts under Section 8, 7; Varying Order from Guardianship, 1.

Three patients were placed under Guardianship—1 by a Guardianship Order obtained under Section 6 of the Mental Deficiency Act 1913 and 2 by Varying Orders from Institutional care.

In addition 258 patients were placed under Statutory Supervision, and 76 patients were removed from the Statutory Supervision list as being no longer in need of further supervision (the above figures are inclusive of action taken in the 245 cases mentioned above who were ascertained during 1956). The total number of ascertained mentally defective persons in the Administrative County on the 31st December, 1956 was 4505:—Under Statutory Supervision, 2244; under Guardianship, 64; in " places of safety " Nil; in Hospitals, 1769; and under Voluntary Supervision 428. Of the patients in domiciliary care 138 were awaiting admission to Hospital, of whom 56 (including 22 " cot and chair " cases) were in urgent need of accommodation.

TRAINING.—Training was considered desirable for 973 of the mentally defective persons under domiciliary care, as follows:—

	Under age 16 years		*Aged 16 years and over*		
	M.	*F.*	*M.*	*F.*	*Total*
(a) Occupation Centre	221	205	51	158	635
(b) Industrial Centre	2	8	99	33	142
(c) Home teaching	22	22	34	118	196
	245	235	184	309	973

Of these, 740 were receiving training, as follows:—

	Under age 16 years		*Aged 16 years and over*		
	M.	*F.*	*M.*	*F.*	*Total*
(a) In Occupation Centres	127	101	13	39	280
(b) In Industrial Centres	1	2	15	—	18
(c) At home	14	20	36	89	159
(d) In Group Training Classes	64	70	46	103	283
	206	193	110	231	740

Of the remainder of the mentally defective persons in community care 880 (594 males and 286 females) were in full-time employment, 44 (30 males and 14 females) were in part-time employment and 859 (322 males and 537 females) were considered to be adequately occupied at home.

The voluntary evening class held by one of the Social Workers for adult female patients has been attended this year by nine patients, three of whom are on licence from Institutions and who are in employment at a nearby Hospital. This evening class is well appreciated by the girls and gives them an opportunity of meeting together informally and discussing any problems they may have with the Social Worker. A day visit to Knaresborough in June was well supported by the National Association of Parents of Handicapped Children and a Christmas Party was very well attended.

Three of the 15 Occupation Centres to be provided by the County Council are already established at Castleford, Keighley and Hemsworth. The adaptations to provide accommodation for an adult male workroom at the Keighley Centre are complete and a male instructor has been appointed and will commence duty on the 1st January, 1957. It is anticipated that there will be an immediate and growing attendance at this class. The class for adult males at the Hemsworth Centre is not yet operating as it has not been possible to obtain the services of a suitable instructor.

The adaptations at " The Gables," Wombwell, are nearly completed and it is hoped to open this small centre very early next year; the work of adapting the premises formerly used as a Day Nursery at Holme House, Lightcliffe, are also well advanced and this small centre will probably be ready for opening in April 1957. The alterations to the former Divisional Health Office at Ossett have commenced and it is expected that the work of adapting the former Day Nursery at Horsforth will commence in the very near future. By July 1957 it is anticipated that seven Occupation Centres will have been established.

The provision of larger centres and the order in which this provision shall be made have been reconsidered by the Mental Health Sub-Committee during the year and bearing in mind as far as possible the provision already existing in the areas to be served by the proposed centres, the accessibility of the premises for the maximum number of patients, the means of conveyance and the probable saving on existing training arrangements likely to be affected by the new provision the Sub-Committee decided that the order of priority to be observed in connection with the five schemes in hand for the erection of new Occupation Centres should be—1. Castleford, 2. Adwick le Street, 3. Ecclesfield, 4. Wath upon Dearne, 5. Maltby.

Suggestions have also been made to the Sub-Committee as to the siting of other centres in addition to those mentioned above but at the present time no order of priority of provision has been decided. Many probable sites and premises have, however, been investigated for the provision of an Occupation Centre in the Heckmondwike area but to date nothing suitable has been found.

The scheme of teaching patients in small groups in varied premises such as Sunday Schoolrooms, Clinic premises etc., has developed further during the year and at present there are 46 such groups ranging from small classes which are held on only one half day per week to larger classes which can be more conveniently held on three and four whole days per week and where school meals can be provided at mid-day. The system of group training classes is an invaluable addition to the training of those children who cannot attend Occupation Centres and who might otherwise receive only a limited amount of training in their own homes. One important result is that children do receive and benefit from contact with other children of similar age and ability with a consequent improvement in social behaviour. Teaching children of this type is hard work calling for concentrated effort and patience on the part of the Teachers. Parents and patients are ever appreciative of their kindly care, training and understanding to which I must add my own sincere appreciation.

The County Council's scheme also provides for co-operation with other Local Health Authorities in the establishment of joint Centres; for West Riding defectives to be admitted to Centres provided by other Authorities; for the provision of Teachers who visit mentally defective persons and care and after-care patients in their own homes; and also for the provision by the Mental Health Social Workers of some training for defectives in isolated parts of the County. West Riding defectives are admitted to Centres provided by the Leeds, Bradford, Barnsley, Burnley, Dewsbury, Doncaster, Huddersfield, Oldham, Rotherham, Wakefield and York County Borough Councils and in addition arrangements have been made with the Hospital Management Committee for a few West Riding defectives to be admitted to the Westwood Hospital School, Bradford, for daily training.

Castleford Occupation Centre.

(Dr. J. M. Paterson, Divisional Medical Officer.)

The practical progress made at the Occupation Centre during the year could be assessed only in the light of two important factors: the first of these was related to the attendances and the second to the type of pupil who had been admitted. Because of the wide extent of its catchment area, coupled with the greater susceptibility of such children to contract colds and other intercurrent infections, the average attendance at the Centre was lower during the winter than the summer. One of the primary aims of an Occupation Centre is to teach the children how to repress undesirable anti-social tendencies and to replace them by habits and standards of behaviour by means of which they will be in a better position to adjust themselves to their environment without any great fear of coming into conflict with the accepted standards of the community.

Since much of the responsibility for doing this lies with the teachers at the Centre and since they take this duty most seriously, any factors which cause them to fall short of these ideals such as the one mentioned give rise to feelings of frustration and labour wasted.

As regards the second factor, it was noted that the type of child admitted tended more towards the lower grades and this in turn demanded on the part of the teaching staff a greater emphasis on sense and speech training. The progress made in the former of these two was disappointing but in the latter the results were much more encouraging. In view of the poor speech of many of these children singing is naturally poor, and in spite of the

enjoyment derived from such lessons the results again were disappointing. The success of other musical lessons, such as eurhythmics and percussion band, however, more than made up for this disappointment. Many of the children who had originally been taught to read from coloured charts have left the centre and after a considerable amount of very hard work, several of the newcomers were successful in coming up to this standard.

In spite of the fact that the facilities for training in domestic subjects are limited, good progress has been made and it is interesting to note that as a result of such training some of the older girls are now quite capable of doing certain of these duties without supervision. Handwork continues to be of a high standard and the accent has been on mending, darning, and knitting for the girls so as to make them more useful citizens in the home. Where one's efforts are unco-ordinated and isolated at the periphery it is extremely difficult to formulate a yardstick by means of which we are enabled to compare our own activities with similar establishments, and the report of the Inspector of the Board of Control proved most interesting reading, thus giving a truer perspective of the work done. The Inspector commented favourably on the type and standard of the handwork carried out and was most impressed by the individuality of the percussion band as well as the remarkably good discipline which was obtained in spite of having all the pupils in one and the same classroom.

The Parent Teachers' Association formed some two years ago to provide a more common understanding between parent and teacher of the problems peculiar to mental defectives and also to provide such extras for the Centre as could not be obtained otherwise has had a most successful year. The composition of this Committee has altered somewhat from the previous year, and it is gratifying to be able to report that the new members are rapidly identifying themselves with the movement. During the year it financed an outing to Bolton Abbey, provided the prizes for the best costume in the Fancy Dress Parade, and in conjunction with the Mental Health Sub-Committee was instrumental in providing a most successful Christmas Party and also another outing to Filey.

Branshaw View Occupation Centre, Keighley.

(Dr. H. M. Holt, Divisional Medical Officer.)

The number of children in attendance has increased. The number in attendance on the 30th November 1955 was 33 as against 36 on the same day 1956. The number of children on the register was 41 in November 1955, as against 43 in November 1956, in the following age groups:—

Sex	Ages—Years																
	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
M	1	1	4	—	2	4	3	3	2	2	1	1	2	2	—	—	—
F	—	1	—	—	—	1	1	2	2	1	3	—	—	1	2	—	1

The consolidation of a staff adequate to the needs of the Centre has occupied a good deal of attention. A part-time Nursery Assistant and a Mental Health escort have been added to the original establishment.

A class for the training of older children has become a reality, a Male Handicrafts Instructor has been appointed and the class promises to be a most successful asset in the development of the Centre.

The Committee approved a scheme for the provision without charge of milk to mental defectives who are under 16 years of age and are in attendance at full-time Occupation Centres in accordance with a recommendation contained in Ministry of Health Circular 12/56, dated 2nd July, 1956.

The Centre is fortunate in having the whole-hearted co-operation of the parents who are at pains to provide additional comforts and assist in contributing to the expense of outings and other recreational functions.

The Parks Committee of Keighley Corporation is to be thanked for the interest and co-operation rendered in connection with the maintenance of the grounds to the enhancement of the amenities of the Centre.

The Staff work amicably together and the relationship between the Supervisor and the Divisional Office leaves nothing to be desired.

Hemsworth Occupation Centre.

(Dr. J. S. Walters, Divisional Medical Officer.)

During the year all the children in the area requiring occupation centre training were finally admitted and at the end of the year the Centre was filled to capacity with 37 children on the register. Unfortunately, the vacancy for a male assistant supervisor remained unfilled and six adult males were still awaiting admission. The permanent Supervisor returned to duty in March and an additional nursery assistant—bringing the total to 3—was appointed in May.

Attendance has been remarkably good throughout the year, the average daily attendance being 33. The Centre seemed to escape the usual minor epidemics which the local schools experienced.

The curriculum was gradually extended as the children settled down and gardening, housewifery, cookery and laundry were added as additional equipment was received. A speech therapist held a short weekly session at the Centre and through this and regular speech training lessons by the staff, the speech of even the most unintelligible children has improved remarkably.

On the 22nd June all the children were taken by coach to Filey on what it is hoped will become an annual outing. The weather was fortunately fine and the children had a very happy day.

An open-day and sale of handwork was held on the 5th December and was very well attended by parents, who seemed to enjoy the displays of dancing, group singing and particularly the enthusiastic efforts of the percussion band.

The first meeting of the Parent Teachers' Association was held in October, with a second meeting in November, but the response from parents was surprisingly poor and it is obviously going to be difficult to advance this aspect of the Centre's activities.

The year 1956 has been one of steady progress; the children have settled down happily to the daily routine and there has been a real improvement in discipline and social behaviour. The staff have worked hard and now have the full confidence of the children and the considerable outside interest in the work of the Centre was again demonstrated by the variety and abundance of gifts which arrived for the Christmas Party.

PART V

ENVIRONMENTAL HYGIENE

Milk

The County Council has again carried out its obligations as a Food and Drugs Authority and as a Licensing Authority for the Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949–53.

The following list gives the names and addresses of licensees:

PASTEURISED MILK

Busfield & Hargreaves, Rawson Dairy, Old Fold, Farsley, near Leeds.
Crawshaw, J., Blake Lea Dairy, 103 Arksey Lane, Bentley, near Doncaster.
Doxey, C., Armthorpe Dairy, Armthorpe, near Doncaster.
Dobson's Dairies, Ltd., Coates Factory, Barnoldswick.
Doncaster Co-operative Society, Ltd., York Road, Doncaster.
Goole Co-operative Society, Ltd., Centenary Road, Goole.
Harrison, R. H., Manor Farm, Conisbrough.
Kirkby Malzeard Dairy Co., Ltd., Kirkby Malzeard, near Ripon.
Mawer, J., & Sons, Glentworth House, Skellow, near Doncaster.
Ivanhoe Dairy, 37 Church Street, Conisbrough.
Mudd, Miss B. J., Aldborough Dairy, Aldborough, Boroughbridge.
Oates, J. E. & E., North Eastern Road, Thorne, near Doncaster.
Pontefract Industrial Co-operative Society, Ltd., Horsefair, Pontefract.
Rotherham Co-operative Society, Ltd., Progress Drive, Bramley, near Rotherham.
Salmon, P. J., Orchard House, Littlethorpe, near Ripon.
Stocksbridge Co-operative Society, Ltd., Shay House Lane, Stocksbridge, near Sheffield.
Victoria Road Dairy, Ltd., Burley in Wharfedale, near Leeds.
West Marton Dairies, Ltd., West Marton, Skipton.
West Riding Dairy Farmers (Wholesale), Ltd., Allan Park Dairy, Sowerby Bridge.
Wharfedale Creamery Co., Ltd., Bolton Bridge Road, Ilkley.
Whittaker's Wholesale Dairies, Ltd., 77 Tenter Balk Lane, Adwick le Street.
Wholesale Dairies (Rotherham and District), Ltd., Claypit Lane, Rawmarsh.
Wild, A., Prospect Farm, Grotton, near Oldham.
Windhill Co-operative Society, Ltd., Thomas Place, Windhill, Shipley.
Yates, A. E., 822/824 Halifax Road, Hightown, Liversedge, Cleckheaton.

STERILISED MILK

Wholesale Dairies (Rotherham and District), Ltd., Claypit Lane, Rawmarsh.

Note.—The licensees whose names appear below ceased to pasteurise milk during the year:

Victoria Road Dairy, Ltd. West Riding Dairy Farmers (Wholesale), Ltd. A. E. Yates.

Regular visits were made to licensed premises for the purpose of ascertaining whether the conditions attached to the licences were being observed and for checking the temperatures of milk under treatment, cleanliness of premises and personnel, etc., and in general to see that plant and other equipment were satisfactory.

Milk in relation to which the special designation "Pasteurised" is used shall be pasteurised, i.e.: (a) retained at a temperature of not less than 145°F. and not more than 150°F. for at least 30 minutes (the "Holder" system); (b) retained at a temperature of not less than 161°F. for at least 15 seconds (the "High Temperature, Short Time" system). Milk treated by either system must be immediately cooled to a temperature not exceeding 50°F. At the end of the year (excluding the three licensees who ceased to pasteurise milk) 9 plants were of the "Holder" type and 13 were "High Temperature, Short Time".

Pasteurised milk samples are subjected to the phosphatase and methylene blue tests. The former is to prove the efficiency of the treatment as to whether or not the milk has been properly pasteurised or whether any raw milk has become mixed after treatment. The methylene blue test shows the keeping quality of the treated milk.

Sterilised milk must be filtered or clarified, homogenised and heated to and maintained at such a temperature, not less than 212°F. for a period as to ensure its compliance with the prescribed turbidity test.

Samples obtained during the year, with results of the examinations, are as set out below:

	Number Obtained	Phosphatase Test		Methylene Blue Test		Turbidity Test	
		Satisfactory	Un-satisfactory	Satisfactory	Un-satisfactory	Satisfactory	Un-satisfactory
Tuberculin Tested (Pasteurised)	73	72	1	73	—	—	—
Pasteurised	442	441	1	442	—	—	—
Sterilised	24	—	—	—	—	24	—

Immediate investigations were carried out regarding any unsatisfactory results and the Senior Area Milk Officer of the Ministry of Agriculture, Fisheries and Food was informed in each instance. The Ministry of Food, Milk Division; later the Ministry of Agriculture, Fisheries and Food, Milk Products Division, was supplied with details of all sample reports as a routine measure each month. Copies of reports were also forwarded to the Medical Officers of Health for the districts concerned.

I have to thank the Director of the Public Health Laboratory, Bradford, for supplying copies of reports on samples of pasteurised milks obtained from producers licensed by the County Council and from dealers who obtain their supplies from these producers. In all 166 samples were reported and in every case the results were satisfactory.

Sampling of Milk Produced at Hospital Farms.—From March to November, at the request of the Ministry of Health, samples of milk are obtained at hospital farms. The list below gives details for the year under review:

Hospital	Methylene Blue Test		Biological Examination
	Number Obtained	Number Satisfactory	Tubercle and Brucella Abortus
Menston, near Ilkley	12	9	
Middlewood, near Sheffield	2	2	All samples obtained during the yearly period were reported as being free from tubercle. (Milk production ceased at Middlewood and Middleton early in the year.)
Middleton, Ilkley	3	3	
Scalebor Park, Burley in Wharfedale	12	10	In the examinations for brucella abortus all samples with the exception of those shown below were negative:
Stansfield View, Todmorden	12	11	Storthes Hall Hospital Farm.
Stanley Royd, near Wakefield	12	7	27.7.56 Agglutination Positive, 1/40 culture positive.
			15.10.56 Agglutination Positive, 1/320 culture negative.
St. John's, Keighley	12	12	
Storthes Hall, Kirkburton	12	12	

It is gratifying to note the complete absence of tubercle bacilli in these samples which were obtained after all cows comprising the herds at the time of the visit had been milked. The low incidence of brucella abortus infection is also worthy of note. The Ministry of Agriculture, Fisheries and Food is immediately informed in the event of any positive biological results. Copies of all sample reports are forwarded to the Medical Officer of Health concerned and to the Hospital Boards.

"Specified Areas" for the Sale of Milk.—Section 41 of the Food and Drugs Act, 1955, enables the Minister of Agriculture, Fisheries and Food and the Minister of Health to bring into operation by Order the provisions of subsection 37(1) of the said Act, relating to the compulsory use of special designations for retail sales of milk, in any area of England and Wales in which it is not then in operation.

The Section has the effect in a "Specified Area" that only pasteurised, sterilised or tuberculin tested milk may be sold by retail in that area.

During the year two "Specified Areas" came into operation in the Administrative County area, namely:

1. The Milk (Special Designations) (Specified Areas) Order, 1956, which included the Urban Districts of Adwick le Street, Bentley with Arksey, Conisbrough, Dearne, Maltby, Mexborough and Tickhill, along with the Rural Districts of Doncaster and Kiveton Park.

2. The Milk (Special Designations) (Specified Areas) (No. 2) Order, 1956, which included the Borough of Goole, the Urban District of Selby, and the Rural Districts of Goole, Selby and Thorne.

At the end of the year the following County Districts are in "Specified Areas":

Municipal Boroughs: Batley, Brighouse, Goole, Morley, Ossett, Pudsey, Spenborough.

Urban Districts: Adwick le Street, Aireborough, Bentley with Arksey, Conisbrough, Cudworth, Darfield, Darton, Dearne, Denholme, Dodworth, Elland, Heckmondwike, Horsforth, Hoyland Nether, Ilkley, Kirkburton, Maltby, Mexborough, Mirfield, Otley, Queensbury and Shelf, Rawmarsh, Royston, Selby, Swinton, Tickhill, Wath upon Dearne, Wombwell, Worsbrough.

Rural Districts: Doncaster, Goole, Kiveton Park, Rotherham, Selby, Thorne, Wharfedale.

The population in these districts now receiving supplies of designated milk is approximately 50 per cent. of the population in the Administrative County. It is known, however, that several other districts are receiving supplies of designated milk but are as yet not included in specified areas.

Sampling of Designated Milk in Specified Areas

Tuberculin Tested (Pasteurised)		Pasteurised		Sterilised		Tuberculin Tested	
Sat.	Unsat.	Sat.	Unsat.	Sat.	Unsat.	Sat.	Unsat.
335	1	365	1	92	—	326	49

The work entailed in carrying out the essential duties in connection with these Areas has involved the assistance of the Public Health Inspectors in the County Districts concerned and I wish to thank them for their valued co-operation with the County Public Health Inspectors.

Supply of Milk to School Children (Milk-in-Schools Scheme).—The Provision of Milk and Meals Regulations, 1945. The Provision of Milk and Meals Amending Regulations, 1956.

On the 1st September, 86 private and other schools were brought into the milk-in-schools scheme under the above Amending Regulations. Details of the milk supplied to all schools are as follows:

	Milk Supplied		
Number of Schools	Pasteurised	Tuberculin Tested	Ordinary	Tuberculin Tested from School Farms
1,361	1,326	32	1	2

	Samples Obtained		
	Total	Satisfactory	Unsatisfactory
Pasteurised	450	440	10
Tuberculin Tested	50	40	10
Ordinary	9	8	1
Total	509	488	21

73 visits were made to premises where school milk is dealt with for approval and inspection purposes, apart from routine visits to licensed pasteurised milk establishments from which milk is supplied to schools.

Biological examinations of samples of "ordinary" milk carried out by the Public Health Laboratory, Wakefield, revealed negative results for tubercle bacilli in all submitted.

Ice-Cream

The following table gives the numbers of manufacturers, retailers, etc., together with the number of inspections made during the year by the County District Public Health Inspectors:

	Manufacturers	Producer-Retailers	Retailers	Inspections Made
Municipal Boroughs and Urban Districts..	29	104	3,436	3,095
Rural Districts	3	29	933	1,059

	Samples obtained			
	Grade 1	Grade 2	Grade 3	Grade 4
Municipal Boroughs and Urban Districts ..	817	111	40	23
Rural Districts	364	80	21	14
Totals	1,181	191	61	37

The Food Hygiene Regulations, 1955

The Food Hygiene Regulations (No. 1906, 1955) were made jointly by the Minister of Agriculture, Fisheries and Food and the Minister of Health in exercise of their powers under the Food and Drugs Act, 1955. The Order was laid before Parliament on 21st December, 1955, and, with certain deferments to 1st July, 1956, came into operation on 1st January, 1956.

These Regulations are regarded as specifying minimum conditions which must be complied with and enforced. They lay down requirements in respect of (i) the cleanliness of food premises and stalls etc., and of apparatus and equipment, (ii) the hygienic handling of food, (iii) the cleanliness of persons engaged in the handling of food and of their clothing, and the action to be taken where they suffer from, or are carriers of, certain infections, (iv) the construction of food premises, the repair and maintenance of food premises, stalls, vehicles, etc., and the facilities to be provided, and (v) the temperature at which certain foods that are particularly liable to transmit disease are to be kept in food premises.

These Regulations also prescribe the higher penalties provided for in Section 106 of the Food and Drugs Act, 1955.

The effect of these Regulations regarding school kitchens and canteens controlled by the County Council was deemed to be of considerable importance and on the 12th October, 1956, a memorandum was addressed to all Medical Officers of Health in the Administrative County area requesting them, or the Public Health Inspectors who may have any schemes for improvement, to acquaint the County Medical Officer or the Chief Education Officer of any proposals in order that meetings could be arranged for discussion purposes and for arrangements to be made to carry out the improvements.

Below is a summary of works authorised during the 1956/57 financial year in order to bring premises occupied by the School Meals Service into line with the Hygiene Regulations:

	Estimated Cost £
Provision and installation of 170 washbasins in school kitchens	3,325
Provision, as a temporary measure, of polythene bowls in 46 kitchens which have insufficient space for the installation of washbasins and 83 polythene bowls in schools	33
Provision and installation of 39 washbasins in receiving schools and dining centres for use of School Meals Service staffs	797
Extension of hot water to washbasins in school cloakrooms where these can be used by School Meals Service staffs (3 schools)	52
Provision of 131 wardrobes for use by School Meals Service staffs	1,480
Minor Building Projects in the Authority's Minor Building Programme for 1956/57 which include works necessitated by the Hygiene Regulations: for example, reorganisation of kitchens, improvement of washing-up facilities in schools and dining centres, installation of ventilating plant, partitioning of cloakrooms, improvement of lavatory accommodation, fly-proofing of windows—(82 projects)	20,016
Total estimated cost	£25,703

Atmospheric Pollution

The Measurement of Atmospheric Pollution—The County Council's scheme for the measurement of atmospheric pollution has continued throughout the year in co-operation with the Department of Scientific and Industrial Research, Medical Officers of Health and Public Health Inspectors in certain County Districts.

This scheme, which entails a considerable amount of supervision of recording instruments, could not have been efficiently undertaken without the assistance of the staffs in the County Districts and I wish to accord my thanks to all who have contributed in the year's work.

The instruments used are of standard pattern being in accordance with the specifications laid down by the Department of Scientific and Industrial Research.

The extent of pollution by deposited matter is determined by exposing a deposit gauge for a period of one month and then examining the solid and liquid fractions of the sample. The lead peroxide instrument is used for estimating the amount of atmospheric sulphur dioxide, the method being to expose a small cylinder or "candle" coated with lead peroxide to the air for one month and then to have it analysed for sulphates. These processes are repeated each month and the chemical examinations in connection with these instruments thus form a month-to-month record of variations in pollution. The daily smoke filter is used for making regular observations of the daily average concentration of smoke and suspended matter, these terms being applied to particles of soot, etc., which are very small and settle to the ground slowly or not at all and, therefore, are not collected to any large extent by deposit gauges.

The results of the analyses in connection with the deposit gauges and lead peroxide instruments, together with the average daily suspended impurity as measured by the daily smoke filters, are shown in the following table:

Situation of Instruments	Deposit Gauge				Sulphur Measurements by Lead Peroxide Method	Situation of Daily Smoke Filter	Average Daily Suspended Impurity
	Rainfall in inches		Total solids deposited in tons per sq. mile		Milligrams SO_3 per 100 sq. cms. per day		Milligrams per cubic metre
	Monthly Average	Total*	Monthly Average	Total*	Average		Average
Skipton—Behind Town Hall in industrial and residential area.	2·82	28·15 for 10 months	17·97	179·67 for 10 months	0·92 for 11 months		
Keighley—Abattoir, Hardings Road in mainly open country.	1·95	19·46 for 10 months	18·12	181·23 for 10 months	1·60 for 10 months	First floor of Public Health Dept., in a built-up area in centre of town.	0·161
Keighley—Oldfield, Oakworth in windy moorland country.	2·25	20·22 for 9 months	13·68	123·16 for 9 months	1·70 for 10 months		
Keighley—Low Bridge, dense industrial area.	2·26	18·06 for 8 months	17·48	139·83 for 8 months	2·09 for 10 months		
Keighley—Library, built-up area in centre of town.	2·18	21·75 for 10 months	20·14	201·41 for 10 months	2·56 for 10 months		
Bingley—St. Ives Research Station in parkland and residential area.	2·81	33·72	9·83	117·92	1·33	In grounds of St. Ives Research Station, in parkland and residential area.	0·076
Bingley—Town Hall in manufacturing and residential area.	2·74	27·44 for 10 months	10·81	108·11 for 10 months	0·86		
Shipley—Somerset House Clinic in manufacturing and semi-residential area.	1·63	17·95 for 11 months	12·71	139·79 for 11 months	1·35		
Horsforth—Broadgate Walk, residential area.	2·54	30·46	15·40	184·82	1·73		
Aireborough—Yeadon Moor, Yeadon Waterworks. Agricultural N.W. to S.E., manufacturing S.E. to W.	2·05	24·55	18·25	218·95	1·82	Public Health Inspector's Office, Yeadon High Street, residential to W., open country to E.	0·093 for 9 months
Otley—Nursery Gardens, Westgate, manufacturing and semi-residential.	2·72	32·66	16·67	200·01	1·19	First floor of Council Offices, in town centre, mainly manufacturing.	0·122 for 10 months
Ripon—Engineer's Depot, residential area.	2·57	30·87	10·47	125·60	1·22	Health Dept., High Skellgate, in centre of country town.	0·151
Harrogate—Roof of Municipal Offices, residential and commercial. Inland Spa.	2·95	35·34	10·52	126·24	1·46	Laboratory, Royal Baths. Inland Spa.	0·085
Wetherby—Council Offices, residential, surrounded by open country from ½ to ¾ mile distant.	2·45	29·38	8·96	107·54	0·92	Council Offices, residential, surrounded by open country from ½ to ¾ mile distant.	0·113
Goole—Health Centre, Bartholomew Avenue, residential and industrial.	2·20	26·42	13·37	160·49	1·29	Div. Health Office, in residential and industrial area.	0·224

* For period of full year unless stated otherwise.

Situation of Instruments	Deposit Gauge				Sulphur Measurements by Lead Peroxide Method	Situation of Daily Smoke Filter	Average Daily Suspended Impurity
	Rainfall in inches		Total solids deposited in tons per sq. mile		Milligrams SO_3 per 100 sq. cms. per day		Milligrams per cubic metre
	Monthly Average	Total*	Monthly Average	Total*	Average		Average
Castleford—Roof of Marks and Speneer's shop, Carlton Street, in centre of industrial town.	2·35	28·23	17·29	207·43	2·93	First floor of Div. Health Offiee, in residential area.	0·229
Castleford—Roof of Cleansing Station, Cinder Lane, manufaeturing area. Chemical works immediately adjacent.	2·28	20·56 for 9 months	22·92	206·31 for 9 months	3·15		
Castleford—Corpn. Pumping Station, Ings Lane, manufaeturing area.	1·92	23·06	15·94	191·31	2·07		
Castleford—Corpn. Housing Depot, Redhill Road, Airedale. Industrial and residential area.	2·00	22·01 for 11 months	10·95	120·42 for 11 months	2·17		
Horbury—Carr Lodge Park, residential and manufacturing to north, open eountry to south.	2·22	26·58	14·98	179·80	1·60	Sewage Works, ¾ mile south of town centre, north manufaeturing and residential, south open country.	0·168
Morley—Flat roof of Co-operative Society premises, residential, commereial and manufacturing.	2·66	31·88	18·84	226·12	2·01	Public Health Inspector's Offiee, Commereial Street, in centre of mixed residential, commercial and manufacturing town.	0·230
Batley—Flat roof of one storied building at rear of P. H. Dept., Market Plaee. Centre of town. Mixed residential, commercial and manufaeturing.	2·50	29·97	18·62	223·41	1·87	Public Health Dept., Market Plaee in centre of mixed residential, eommercial and manufacturing area.	0·278
Rothwell—Central Clinic, Oulton Lane, residential.	2·18	26·14	14·78	177·35	1·67	Div. Health Office, Oulton Lane, in residential distriet.	0·202
Spenborough—Corpn.'s Depot, Marsh. North, south and west—manufaeturing area, open country to east.	2·50	29·94	15·31	183·77	2·10	Div. Health Office, Elm Bank, in industrial and manufacturing area.	0·216
Elland—"Ellen Royd," Public Library in manufaeturing area.	2·82	33·89	12·98	155·78	1·81	First floor of Council Offices, in manufacturing area.	0·204
Hebden Royd—Redaere Sewage Works, Mytholmroyd, residential and manufacturing area, open country to north.	2·93	35·10	16·40	196·85	1·54	Redacre Sewage Works, Mytholmroyd, residential and manufacturing area, open country to north.	0·127 for 11 months
Colne Valley—Sewage Works, Slaithwaite, in mixed residential and textile manufaeturing district.	2·90	31·90 for 11 months	16·13	177·41 for 11 months	2·18 for 11 months	Town Hall, Slaithwaite, in mixed residential and textile manufacturing district.	0·153
Colne Valley—Marsden Park, residential and manufaeturing area.	3·05	30·49 for 10 months	12·75	127·46 for 10 months	1·35 for 11 months		

* For period of full year unless stated otherwise.

Situation of Instruments	Deposit Gauge				Sulphur Measurements by Lead Peroxide Method	Situation of Daily Smoke Filter	Average Daily Suspended Impurity
	Rainfall in inches		Total solids deposited in tons per sq. mile		Milligrams SO_3 per 100 sq. cms. per day		Milligrams per cubic metre
	Monthly Average	Total*	Monthly Average	Total*	Average		Average
Holmfirth—Sewage Works, Neiley, Brockholes, residential and manufacturing.	3·02	30·23 for 10 months	9·45	94·47 for 10 months	1·04 for 11 months		
Saddleworth—Sewage Works, Shaw Hall Bank, Greenfield, residential, manufacturing and commercial.	2·73	29·99 for 11 months	14·17	155·87 for 11 months	1·82	Sewage Works, Shaw Hall Bank, Greenfield, residential, manufacturing and commercial.	0·127
Wortley—Hallwood Hospital grounds, Grenoside, open country and woodland.	2·71	32·53	10·93	131·16	0·98	Health Department, Council Offices, Grenoside, industrial and manufacturing area.	0·186
Hemsworth—Vale Head Park, parkland, surrounded by open country.	1·99	23·90	12·34	148·10	1·53	Div. Health Office, Adiscombe House in residential district.	0·202 for 11 months
Darton—Grounds of Council Offices, semi-residential, colliery district. Coke by-product plant 1 mile to S.E.	2·42	26·64 for 11 months	14·32	157·47 for 11 months	1·28	Council Offices, semi-residential, colliery district. Coke by-product plant 1 mile to S.E.	0·114
Wombwell—The Gables, semi-residential, colliery district.	2·36	28·26	15·30	183·62	1·41	The Gables, semi-residential, colliery district.	0·280 for 10 months
Rawmarsh—Roof of Clinic, Barbers Avenue, residential and industrial.	2·02	24·21	22·25	267·01	1·92	Public Health Inspector's Office, in centre of residential and industrial area.	0·473
Rawmarsh—Grounds of Granby House, Aldwarke Road. Blast furnaces 200-300 yards distant.	2·10	25·16	73·85	886·25	3·34		
Bentley with Arksey—Bentley Park, Askern Road, semi-residential, colliery district.	1·95	21·40 for 11 months	14·42	158·63 for 11 months	1·21	Council Offices, in centre of semi-residential area, colliery district.	0·194
Doncaster—Between Church and Vicarage, Askern. Industrial and residential, colliery district.	2·01	24·06	24·51	294·14	1·85		
Thorne—Grounds of Council Offices, semi-residential, colliery district.	1·85	20·40 for 11 months	10·34	113·79 for 11 months	1·06	Council Offices, town centre in semi-residential area, colliery district.	0·092 for 10 months
						Maltby—Council Offices, one mile west of town centre, semi-residential, colliery district.	0·112

* For period of full year unless stated otherwise.

Situation of Volumetric Sulphur Dioxide Apparatus	Sulphur Measurements by Volumetric Method
	SO_2 in parts per million
	Average
Hebden Royd—Redacre Sewage Works, Mytholmroyd, residential and manufacturing area.	0·040 for 11 months
Aireborough—Public Health Inspector's Office, Yeadon High Street. Residential to W., open country to E.	0·030 for 9 months

Clean Air Act, 1956.—An Order laid before Parliament on 21st December, 1956, named 31st December, 1956, as the day on which certain sections of this Act would come into operation. These are as set out below:

New Furnaces.—All new furnaces, other than small domestic boilers, must be so far as practicable, smokeless. Notice of intention to install such a furnace must be given to the local authority.

Smoke Measurement.—The Minister is empowered to make Regulations requiring furnaces to be fitted with smoke density meters.

Height of Chimneys.—The height of new chimneys, other than those of houses, shops and offices, will require approval by the local authority.

Smoke Control Areas.—Local authorities may make Smoke Control Orders which will be subject to confirmation by the appropriate Ministry.

Special Cases.—For premises scheduled under the Alkali, etc., Works Act the provisions of the Clean Air Act that are now operative are the responsibility of the Alkali Inspectorate.

Colliery Spoilbanks.—All practicable means must be used for the prevention of combustion and the emission of smoke from deposits from coal or shale mines or quarries.

Research Exemptions.—Local authorities may temporarily exempt from action under the Act premises where research relevant to the prevention of air pollution is being conducted.

Crown Premises.—Local authorities to report cases to the responsible Minister of contravention by Crown premises of a smoke control area order.

Clean Air Council.—The Council may now be established.

Building Bye-laws.—Bye-laws for smokeless heating and cooking in new buildings may be adopted.

Research and Publicity.—Local authorities may incur expenditure on research, education and publicity.

Disclosure of Information.—It is an offence to disclose improperly, information obtained in administering the Act.

Administrative and Legal.—Sections 28 to 37 of the Act come into operation in so far as they are at present applicable.

The principal sections of the Act not yet in operation are those relating to dark smoke, dust and grit, smoke nuisances, railways and shipping. These sections, however, will probably be in force early during 1958.

Smoke Abatement.—The County District Councils are responsible for dealing with nuisances arising from smoke emission and the following table shows the work carried out during the year:

	Number of observations each of 30 minutes duration	Number of these showing excessive emission of black smoke	Number of cautions issued	Number of statutory notices issued	Number of prosecutions	Other action	Bye-laws in force	Districts with colliery spoilbanks	Districts in which firing of colliery spoil-banks reported
Municipal Boroughs and Urban Districts	2,097	221	187	16	2	16	38	29	13
Rural Districts	83	25	25	—	—	—	5	9	7

Sanitary Circumstances

Housing.—In the 68 Municipal Boroughs and Urban Districts there were 396,675 dwelling houses and in the 21 Rural Districts 136,818, giving a total of 533,493.

Details of new houses completed during the year are as follows:

	Local Authority	Private Enterprise	Totals
Municipal Boroughs and Urban Districts ..	3,988	2,280	6,268
Rural Districts	1,429	1,324	2,753

Housing Conditions.—As in former years several requests for assistance in housing problems were received from persons in the County Districts and in every case these were referred to the districts concerned. Special emphasis was made in the case of any member of a family suffering from tuberculosis.

The following table shows action in connection with the Housing Act, 1936, in the Administrative County:

	Unfit Houses	Houses not in all respects reasonably fit for habitation	Demolition Orders made	Houses demolished following Demolition Orders	Closing Orders made	Number of cases of overcrowding at end of year	New cases reported during the year	Cases of overcrowding relieved during the year	Number of defective dwelling houses rendered fit in consequence of Informal Action by their Officers
Municipal Boroughs and Urban Districts	5,590	13,412	595	335	31	1,832	448	623	16,922
Rural Districts	1,867	6,706	402	143	38	538	270	189	2,338

HOUSING ACT, 1936:

	Municipal Boroughs and Urban Districts	Rural Districts
Number of Clearance Areas represented during the year ..	133	27
Number of houses included in these areas	2,139	264
Number of persons to be displaced	5,306	568
Action taken during the year in respect of Clearance Areas:		
(a) by Clearance Orders, number made	71	12
(b) by Compulsory Purchase Orders, number made ..	19	3
Number of houses in Clearance Areas demolished during the year	535	87
Number of persons re-housed from houses demolished during the year	1,931	120

MUNICIPAL BOROUGHS AND URBAN DISTRICTS:	*Housing Act*, 1949. *Section 4. Action in connection with advances for purpose of increasing housing accommodation.*	*Housing Act*, 1949, *as amended by Housing Repairs and Rents Act*, 1954. *Grants to persons other than local authorities for improvement of housing accommodation.*
Adwick le Street	—	1 grant allowed.
Aireborough	23 advances made.	46 applications received, 40 grants approved.
Barnoldswick	—	23 houses, £2,016 18s. 0d.
Batley	Yes.	Yes.
Bentley with Arksey	Loans advances for buying houses.	—
Bingley	—	70.
Brighouse	—	Until November, 1956, a modified form of the Improvement Grant Scheme was operated and 42 applications were received of which 38 were approved. In November, 1956, the Council decided to make no further grant for a period of 6 months.
Castleford	—	22 applications, 20 approved totalling £2,862. Grants paid out £2,846.
Colne Valley	—	54 Improvement Grants approved, 48 completed.
Conisbrough	—	5.
Darfield	—	4 Improvement Grants made to applicants.
Darton	7 loans made.	23 grants made.
Dearne	—	19.
Denby Dale	6 advances approved (3 for acquiring houses, 2 for repairing houses and 1 for building house).	Schemes submitted 3, schemes approved 3, schemes completed during year 12, schemes in progress end of year 8.
Denholme	—	Grants of £150 each in respect of 2 properties.
Dodworth	—	2 grants.
Earby	—	11.
Elland	—	25 Improvement Grants during year.

Municipal Boroughs and Urban Districts:	*Housing Act*, 1949. *Section 4. Action in connection with advances for purpose of increasing housing accommodation.*	*Housing Act*, 1949, *as amended by Housing Repairs and Rents Act*, 1954. *Grants to persons other than local authorities for improvement of housing accommodation.*
Garforth	162 advances made.	—
Goole	—	£5,097 granted for the improvement of 47 dwellings.
Harrogate	—	Yes—grants approved in respect of 47 applications. Approximate nett total of £9,000.
Heckmondwike	33.	7.
Holmfirth	1 application received and advance approved.	19 applications—14 approved and grants made.
Horbury	—	13.
Horsforth	—	18 applications received, 18 granted. Amount granted £1,920.
Hoyland Nether	—	16 grants made amounting to £1,852 13s. 8d.
Keighley	—	105 grants approved.
Kirkburton	—	13 applications received and approved, 9 houses improved during year.
Knaresborough	—	3 applications made and all were granted.
Knottingley	—	Grants made in respect of 6 dwellings.
Maltby	—	5.
Meltham	—	15 applications received and 15 approved. Amount authorised £2,404. 7 completed.
Mexborough	—	10.
Mirfield	15.	10.
Morley	—	10 Improvement Grants to private persons were approved during year.
Normanton	—	Grants recommended in 10 cases.
Ossett	—	15 Improvement Grants.
Otley	—	18 applications received, 16 grants approved.
Penistone	—	Several applications received during the year. All were refused by the Local Authority.
Pontefract	—	2 applications approved, 2 applications refused. Number of grants paid—8. Total amount paid—£1,476 10s. 0d.
Pudsey	—	37 grants made.
Queensbury and Shelf	Advances for purchase of houses now made under this Section instead of under under S.D.A. Act.	25 applications approved in the year to total of £4,640.
Rawmarsh	—	Formal approval for grants for 10 houses, preliminary approval for grants for 4 houses.
Ripon	—	Grants to 10 persons.
Ripponden	—	3 applications approved for grants.
Rothwell	—	28 applications considered, 26 approved. 15 qualified for grants during the year.
Saddleworth	—	Grants made in respect of 2 houses. Total grants £145 5s. 9d.
Selby	—	Yes.
Shipley	—	35.
Silsden	—	14 applications approved for grants.
Skipton	—	7.
Sowerby Bridge	—	Applications 24, withdrawn 1, granted 22, rejected 1.
Spenborough	72 advances totalling £40,417 during the year.	55 applications for grants, 8 refused. Approved grants totalled £6,930.
Stanley	—	14.
Stocksbridge	3 advances made.	21 grants approved.
Swinton	—	6 grants for improvements made.
Todmorden	—	34 applications considered, 30 approved, 1 refused and 3 withdrawn.
Wath upon Dearne	—	16 grants made for improvement of housing accommodation.
Wombwell	—	Grants made in 13 cases.
Worsbrough	—	Grants to 11 persons.

Rural Districts:	*Housing Act*, 1949. *Section 4. Action in connection with advances for purpose of increasing housing accommodation.*	*Housing Act*, 1949, *as amended by Housing Repairs and Rents Act*, 1954. *Grants to persons other than local authorities for improvement of housing accommodation.*
Bowland	—	Housing Improvement Grants paid out in 7 cases (including 4 tenanted houses).
Doncaster	—	54 grants made.
Goole	2 grants for conversion of houses into flats.	Grants made to 17 applicants.
Hemsworth	—	19 grants made.
Hepton	—	5 grants made.
Kiveton Park	—	Improvement Grants paid in respect of 74 properties.
Nidderdale	—	56 grants approved totalling £7,658.
Osgoldcross	3 advances made.	6.
Penistone	Advances to 3 applicants during year.	21 Improvement Grants totalling £5,927 0s. 10d. during year.
Ripon and Pateley Bridge	—	30 completed, 10 in progress.
Rotherham	136.	66.
Sedbergh	—	5 applications approved.
Selby	1 advance of £1,080	6 advances made.
Settle	—	25 applications approved involving a total of £4,950. 32 schemes have been completed.
Skipton	—	34 applications approved. Total approved expenses in executing improvements £15,883 12s. 5d. Amount of grant approved £6,671. Total amount of grant paid in 1956 —£7,267.
Tadcaster	5 applications approved for adaptation of existing houses and other buildings to provide additional units of housing accommodation. 4 units provided during the year.	107 applications received, 97 approved, 6 not approved. 34 houses improved during the year.
Wakefield	32 advances.	37 grants approved.
Wetherby	5.	79 houses.
Wharfedale	—	10 grants approved, 10 claims paid.
Wortley	This Section is operated to a limited extent in connection with loans for house purchase and construction together with the S.D.A. Act.	28 applications received, 6 approved, 5 refused, 9 withdrawn, 8 deferred. 2 schemes approved in 1956 completed.

Housing (Rural Workers) Acts, 1926–42.—The County Public Health Inspectors made 201 inspections at cottages for which grants have been given under the above Acts.

The inspections dealt with the matters of tenancies, rents and structural conditions.

Detailed reports were prepared and forwarded to the Clerk of the County Council who informed the owners of any matters in need of attention.

Closet Accommodation.—

	Total number of closets of all types	*Number of closets on the water carriage system*	*Percentage of closets on the water carriage system*
Municipal Boroughs and Urban Districts ..	440,470	430,133	97·7
Rural Districts	153,000	135,394	88·5
Administrative County	593,470	565,527	95·3

There are approximately 28,000 pail and privy closets.

Public Cleansing.—In the Municipal Boroughs and Urban Districts tipping on the controlled system is generally in use. Mechanical separation is partly used in one district.

In the Rural Districts tipping is generally found to be in use, the majority of tips being on the controlled system, the remainder being semi-controlled.

No complaints have been received by the County Medical Officer as to any nuisances arising from rodent infestation or firing of tips during the year.

Water Supplies.—The table below shows the approximate number and percentage of dwelling houses on public supplies:

	Municipal Boroughs and Urban Districts	*Rural Districts*	*Total*
No. of houses	396,675	136,818	533,493
No. of above on public supplies ..	386,461	128,044	514,505
Percentage on public supplies	97·4	93·6	96·4

Details of water samples obtained by officials of the County Districts and other Bodies are as set out below:

	Chemical Analysis			Bacteriological Examination		
	Number Obtained	Satisfactory	Unsatisfactory	Number Obtained	Satisfactory	Unsatisfactory
Municipal Boroughs and Urban Districts	472	451	21	2,443	2,181	262
Rural Districts	130	118	12	1,580	1,132	448

Particulars regarding the quality, quantity, extensions, closures or restrictions in water supplies during the year:

	Quality		
	Satisfactory	*Not Satisfactory*	*Hard Water*
Municipal Boroughs and Urban Districts ..	66	1	1

	Quantity		
	Satisfactory	*Insufficient in Parts*	*Short Supply*
	64	3	1

	Quality	
	Satisfactory	*Generally Satisfactory*
Rural Districts	19	2

Quantity		
Satisfactory	*Generally Satisfactory*	*Not Satisfactory*
18	2	1

Details of extensions, closures, restrictions, etc.:

Municipal Boroughs and Urban Districts:	*Extensions*	*Closures, Restrictions, etc.*
Baildon	Valley View, Springfield Road.	—
Batley	To new properties.	—
Bentley with Arksey	Extensions made.	—
Bingley	To 4 areas.	—
Brighouse	528 yds. mains to new estates.	—
Castleford	To housing estates.	—
Colne Valley	Extensions made.	—
Conisbrough	To new housing estates in Conisbrough.	—
Darton	Extensions made.	—
Dearne	To new houses erected during the year.	—
Denby Dale	—	Pumping of Huddersfield water restricted.
Denholme	2 in. supply to one farm.	—

Municipal Boroughs and Urban Districts:	*Extensions*	*Closures, Restrictions, etc.*
Garforth	To new estates.	—
Goole	To new estates.	—
Harrogate	To new housing estates.	—
Hemsworth	To new estates.	Higher reaches of district, Hemsworth, Kinsley and Fitzwilliam.
Holmfirth	To Greenfield Road.	—
Horbury	150 yds. 3 in. main at Clifton Close.	—
Horsforth	To new premises.	—
Hoyland Nether	To new housing schemes.	—
Keighley	Extensions made.	—
Knottingley	To new estates.	—
Meltham	To new houses.	—
Mexborough	To housing sites.	—
Normanton	To new houses.	—
Ossett	60 yds. to housing estates.	Restricted for 5 weeks around August.
Otley	To new estate in Weston Lane.	—
Penistone	To new estates.	—
Pontefract	To new estates.	—
Pudsey	To housing estates.	—
Queensbury and Shelf	330 yds. 3 in. main.	—
Rawmarsh	To new houses.	—
Ripponden	To Rishworth Estate.	—
Rothwell	To building sites.	—
Royston	To 20 new houses.	—
Saddleworth	14 houses connected to mains.	—
Selby	500 ft. of 4 in. main.	—
Silsden	—	Outflow from compensation reservoir restricted during summer period to conserve supplies.
Sowerby Bridge	Extensions made.	Private supplies at Sowerby and Midgley.
Stanley	To new estates.	—
Wath upon Dearne	To new houses.	—
Wombwell	To new houses.	—
Worsbrough	136 yds. 4 in. main.	—
Rural Districts:		
Bowland	West Bradford water undertaking formerly owned by a private company now taken over by Council. Supply to 78 houses. Water in bulk from the Council's new main is now supplied to Bashall Eaves and distributed to 6 houses by the Council's main and to 11 houses by an Estate Company. Regional Water Scheme now well in hand and at the end of 1956, 22,200 yds. of main laid.	—
Doncaster	To new housing estates.	—
Osgoldcross	To new estates.	Lack of pressure in northern parishes.
Penistone	New storage tank at Thurgoland.	Inadequacy at times at High Hoyland.
Ripon and Pateley Bridge	Dacre to Darley Link.	Burnt Yates village pump.
Rotherham	Extensions carried out.	—
Selby	One mile of 4 in.	—
Settle	At Newhouse.	—
Skipton	Extensions made.	Some restrictions in drought period.
Tadcaster	10 small extensions.	—
Thorne	36 yds. of 4 in., 670 yds. of 3 in.	—
Wakefield	Extensions made.	—
Wetherby	—	10 private wells closed.
Wharfedale	Extensions made.	—

PLUMBO-SOLVENT WATER SUPPLIES.—Periodical examination of water supplies known or suspected to possess plumbo-solvent properties has been carried out. There are 62 such supplies in the County. Samples were obtained in pairs: (a) after standing for 30 minutes in a lead service pipe, and (b) after standing all night in such a pipe. Examinations were made to determine the presence or absence of lead. It is generally considered that a water supply which is plumbo-solvent to the extent of taking up 1/10th of a grain of lead per gallon is dangerous to health and that the plumbo-solvency of such water should be neutralised. During the year 250 samples were obtained from the 62 supplies. In the case of 2 supplies lead was found present but not in quantities considered dangerous to health.

Drainage and Sewerage.—

	Districts reporting parts still requiring sewering	Districts reporting parts still requiring improvement of sewers	Districts having carried out re-drainage works	Houses not connected to sewers
Municipal Boroughs and Urban Districts	50	23	17	9,196
Rural Districts	21	12	10	14,132

MUNICIPAL BOROUGHS AND URBAN DISTRICTS:	*Sewer Extensions*	*Sewage Disposal Works, Extensions and Remarks*
Aireborough	Greenacre Site, Green Lane, Yeadon, Hawksworth Lane, Guiseley.	—
Baildon	Part of Lucy Hall Drive, The Glen.	All sewage treated at Esholt by Bradford C.B.
Barnoldswick	—	Inadequacy reported.
Batley	To new housing estates.	All Batley sewers now discharge into Dewsbury sewers, thence to Dewsbury disposal works.
Bentley with Arksey	To new housing estates.	Sewage disposal works gradually becoming overworked.
Bingley	30 drains relaid.	—
Brighouse	Toft's Grove and Delph Hill —sewer enlarged and diverted. 740 yds. of 27 in.—21 in. sewer.	Humus tank capacity inadequate.
Castleford	New sewer being laid in Chapel Street, Duke Street and Wheldon Road, to replace existing defective sewer, and to new housing estates.	Inadequacy reported at Whitwood and Fryston.
Colne Valley	496 yds. laid.	Inadequacy reported. Court Orders on 3 Works stand suspended.
Conisbrough	—	Sewage Works at Denaby Main—an improvement scheme has been submitted to the Ministry for grant.
Cudworth	Farfield Cottage 6 in. sewer, septic tank and filter. 9 in. surface water sewer at Stocksmill by W.R.C.C.	—
Darfield	—	To be dealt with in Phase III of the Sewerage Improvement Scheme.
Darton	Work in progress to sewerage scheme at Staincross (added area).	Reconstruction of septic tanks, cleansing of another, abolition of cesspool, abolition of sump.
Dearne	To new housing sites at Thurnscoe, Goldthorpe and Bolton on Dearne.	Inadequacy as further housing programme continues.
Denby Dale	Completion of 1,069 yds. Ridingwood Scheme, Clayton West. 860 yds. Emley Moor completed.	Alterations to Scottscroft Works. Inadequacy at Emley and Heator Bottom. Excessive quantity of surface water to Langley's Works.
Denholme	—	Scheme being prepared to pump sewage from 37 houses at Fieldhead into head of sewer discharging to Whalley Lane Works.
Featherstone	—	Inadequacy reported.

Municipal Boroughs and Urban Districts:	*Sewer Extensions*	*Sewage Disposal Works, Extensions and Remarks*
Garforth	New housing estate sewers and extension at Brigshaw Lane. Sewers damaged by mining subsidence.	—
Goole	To new houses.	—
Harrogate	Harlow Avenue—surface water extension.	—
Heckmondwike	—	Minor modifications of sewage works required.
Hemsworth	To new housing sites at Kinsley and Hemsworth.	Inadequacy at Kinsley and Hemsworth.
Holmfirth	Greenfield Road, Holmfirth.	Scheme under consideration for closing New Mill Sewage Works and extension of Neiley Works.
Horbury	70 yds. combined sewer at Clifton Close.	Insufficient humus tanks.
Horsforth	Cragwood Estate, Lickless Estate, Brownberrie Crescent, West End Lane, Scotland Lane (surface water) re-drainage carried out.	—
Hoyland Nether	To housing schemes.	—
Keighley	393 yds. to private estates.	Morton Sewage Disposal Works inadequate. Scheme submitted for improvement. Scheme submitted for new tank at Marley Sewage Works.
Kirkburton	50 yds. 9 in. sewer Flockton, 490 yds. 9 in. and 6 in. sewer Grange Moor, 690 yds. 9 in. and 6 in. sewer Lepton (private).	Additional filter at Kirkburton Works under construction. 3 new irrigation beds at Flockton.
Knottingley	—	Inadequacy reported, scheme being prepared.
Maltby	—	Inadequacy reported, plans for improvements and extensions in hand.
Meltham	—	Inadequate to deal with increased flow and strong sewage. Extension of Works Scheme awaiting approval.
Mexborough	Clayfield Estate for new houses. Relief sewer from Clayfield Estate to sewer outfall carried out.	—
Mirfield	530 yds. at Crossley Lane.	All sewage treated by arrangement with Dewsbury C.B. New pumping station almost completed.
Morley	Completed stage I of Low Moor Housing Estate.	Main Dewsbury Road Works reconstruction in hands of consulting engineers.
Normanton	To The Crescent, Illingworth Avenue, Parker Avenue, Altofts—new private enterprise houses.	—
Ossett	To housing estates only.	—
Otley	Housing development in Weston Lane.	—
Penistone	Extensions to Council Housing Sites at Shrewsbury Road, Millhouse and Thurlstone, and private estates at Castle Green and Wellhouse Lane, Penistone.	Additional filter beds required at Spring Vale Sewage Works.
Pontefract	—	Carlton Sewage Disposal Works completed. Additional sedimentation capacity required at main works.
Pudsey	880 yds. Carrhill Estate, 770 yds. Owlcotes Estate, 113 yds. Sunfield Drive, 133 yds. Smalewell Drive.	Scheme for re-circulation of effluent commenced at Houghside Works. Proposal regarding scheme for Smalewell Works reconstruction.

Municipal Boroughs and Urban Districts:	*Sewer Extensions*	*Sewage Disposal Works, Extensions and Remarks*
Queensbury and Shelf	Lumbrook Works taken out of use and sewer extended into Brighouse area.	Inadequacy at Woodfall Works, Shelf. Lumbrook Sewage Disposal Works dispensed with.
Rawmarsh	880 yds. to new housing estates.	—
Ripon	Sewer in Grove Lane extended.	2 new bacteria beds completed.
Ripponden	—	Improvements to sludge beds. Barkisland Sewage Works extension scheme awaiting negotiations for acquisition of land.
Rothwell	To housing sites.	Inadequacy at Mickletown and Methley.
Royston	For housing development.	—
Saddleworth	To new housing estates only.	—
Selby	—	No Sewage Works, tidal river.
Silsden	Extension in Skipton Road for private housing development.	Present works have insufficient filter capacity. Investigations proceeding regarding trunk sewer to Keighley.
Skipton	80 yds. 9 in. surface water sewer, 80 yds. 9 in. foul water sewer.	—
Sowerby Bridge	—	Sewage Works only able to cope with domestic sewage.
Spenborough	Re-sewering of Hartshead and new pumping station.	Construction of new Sewage Works at Gomersal. Inadequacy of sewage disposal works still.
Stanley	To new estates.	Extensions to Smalley Bight completed.
Stocksbridge	To housing estates.	Inadequacy reported.
Swinton	To private and local authority schemes.	—
Tickhill	—	Additional sludge beds are required and a scheme is being prepared. Scheme prepared for dealing with surface waters.
Todmorden	—	New detritor and sludge pumping equipment in hand.
Wath upon Dearne	—	Improvements to main outfall sewer and Barnsley Road sewer.
Wombwell	To new Council housing estate and privately owned development sites. Further damage by subsidence to sewers in Pontefract Road and Brampton Road.	Lundhill Sewage Works inadequate.
Worsbrough	1,320 yds. of 6 in., 40 yds. of 9 in. and 180 yds. 12 in. foul sewer. 1,420 yds. of 6 in. surface water sewer.	Additional filter accommodation is desirable.
Rural Districts:		
Bowland	New sewerage system for West Bradford village.	Inadequacy of works at Waddington and Gisburn.
Doncaster	New housing estate at Sunnyside, Kirk Sandall.	Inadequacy at Askern and Rossington —works overloaded.
Goole	—	With the exception of Swinefleet there are no sewage disposal works. Untreated sewage is discharged into water courses.
Hemsworth	To housing estates in Great Houghton and South Kirkby.	New works completed for Havercroft and part of Ryhill. 2 old works abandoned.
Hepton	Short lengths of existing sewers re-laid to connect properties with drainage scheme in Wadsworth.	—
Kiveton Park	New sewer at Letwell completed. Re-drainage work at Majila Cottages completed.	New sewage disposal works at Letwell completed.

Rural Districts:	*Sewer Extensions*	*Sewage Disposal Works, Extensions and Remarks*
Nidderdale	350 yds. at Marton Village. Partial re-drainage at Marton and Hunsingore.	Inadequacy at numerous villages, in most cases schemes prepared.
Osgoldcross	Kellington Housing Estate.	Kellington Estate, filter bed and humus tank. At Brotherton and Fairburn existing works totally inadequate and all other villages, except Darrington, have no sewerage schemes.
Penistone	At Hood Green, Ingbirchworth, Crane Moor.	New works at Ingbirchworth and Crane Moor. Silkstone and Silkstone Common Works overloaded.
Ripon and Pateley Bridge	—	New sewage disposal works at Shaw Mills. Inadequacy at several villages, schemes have been prepared.
Rotherham	Hood Hill, Wentworth and Hooton Roberts.	Brampton Bierlow new sludge bed, Hooton Roberts new works commenced. Inadequacy still reported.
Sedbergh	—	Inadequacy at Sedbergh due to storm flooding.
Selby	—	Sewerage scheme for village of Barlow carried out. With the exception of Barlow and 5 small disposal works on housing sites, there are no sewage disposal works in the district.
Settle	—	Sedimentation tanks at Low Bentham and Clapham. Under drains at Settle.
Skipton	360 lin. yds.—6 in. earthenware, 170 lin. yds.—4 in. C.I. rising main.	Inadequacy reported.
Tadcaster	To 4 housing estates.	Inadequacy in several parishes. 5 major schemes awaiting commencement.
Thorne	—	Inadequacy at Dunston Hill Bridge, Stainforth and Hangman's Hill.
Wakefield	Durkar Estate, Sharlston, Doncaster Road.	Extensions at Bretton, Haigh and Crigglestone. Inadequacy at Horbury Bridge, Kirkthorpe, Sharlston, Bretton, Crofton and Woolley.
Wetherby	Thorner, Rigton, Kearby, Kirkby Overblow.	At Wetherby.
Wharfedale	450 yds. 6 in. pipes at Bramhope.	Inadequacy at Carlton.
Wortley	Sewer laid in part of Dungworth. Extensions in connection with housing development at Chapeltown.	Small sewage disposal works established at Dungworth, primarily to deal with Council development, but intended to deal with village ultimately. Scheme prepared for extension of Wharncliffe Side Works which are overloaded.

Nuisance Inspection and Action.—

	Total No. of Inspections made in 1956 for nuisances only	Notices for Abatement of Nuisances						Total No. of Summonses, etc.
		Informal			Statutory			
		Outstanding at 31.12.55	Issued in 1956	Abated in 1956	Outstanding at 31.12.55	Issued in 1956	Abated in 1956	
Municipal Boroughs and Urban Districts	45,603	3,555	14,726	14,427	861	2,221	2,093	92
Rural Districts	5,089	870	2,296	2,146	287	537	414	16
Totals	50,692	4,425	17,022	16,573	1,148	2,758	2,507	108

Swimming Baths, Pools, etc.—

In the Administrative County the number of Swimming Baths, Pools, etc., are as set out below:

	Public Swimming Baths or Pools	*Privately owned Swimming Baths*	*Privately owned Swimming Baths or Pools open to the public*	*Baths for school use only*	*Paddling Pools*	*Privately owned Riverside Pool open to the public*
Municipal Boroughs and Urban Districts	33	—	2	5	2	—
Rural Districts	1	1	4	—	—	1

These baths and paddling pools receive regular supervision regarding the treatment of water, etc., and samples are obtained for bacteriological and chemical examination.

Prevention of Damage by Pests Act, 1949.—During the year 16 inspections were made by the County Public Health Inspectors at school canteens and kitchens regarding rats and mice infestation. Reports on the structural conditions of the premises were forwarded to the Chief Education Officer. Disinfestation treatment was carried out by the County District Public Health Inspectors and their staffs.

Inspections generally were made in co-operation with the local officials. Action taken by the County District Councils' officials during the year was as follows:

	Number of Inspections	*Infestations dealt with*
Municipal Boroughs and Urban Districts	42,970	5,826
Rural Districts	14,252	2,868

Rural Water Supplies and Sewerage Acts, 1944 to 1955.—Applications for grants during the year are given below:

County District	Description of Scheme	Estimated Amount of Scheme	Date of Application
		£	
Aireborough U.D.	Water Supply to property at Otley Chevin.	2,120	4.6.56
Hemsworth R.D.	New Monkton Colliery, reconstruction scheme for sewage disposal.	10,750	6.3.56
Meltham U.D.	Helme and Wilshaw District sewerage	—	23.10.56
Penistone U.D.	Hoylandswaine sewerage and sewage disposal scheme.	18,000	23.4.56
Penistone R.D.	Carlecotes and Crowedge water supply.	22,500	29.5.56
Ripon and Pateley Bridge R.D.	Markington sewerage and sewage disposal.	18,208	22.2.56
Tadcaster R.D.	Ledsham sewerage and sewage disposal scheme.	9,665	26.1.56
Wath upon Dearne U.D.	Main sewage scheme with branch to West Melton	48,860	22.6.56
Wortley R.D.	Water supply to Coldwell, Oughtibridge	3,500	24.5.56

Summary of Visits and Duties carried out by the County Public Health Inspectors.—

Inspections at dairies under The Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949–53	550
Number of samples of pasteurised and sterilised milks	539
Number of samples of school milks	509
Visits to contractors' premises regarding school milk supplies	73
School milk complaints investigated	27
Visits to hospital farms, and samples, on behalf of the Ministry of Health	77
Visits regarding milk supplies at school kitchens	10
Visits regarding the Food and Drugs Act, "Specified Areas"	767
Inspections under the Housing (Rural Workers) Acts	201
Visits regarding water supplies	5
Water sampling and testing for residual chlorine at special schools, etc.	48
Investigations regarding school sanitary accommodation	2
Investigations regarding complaints in the County Districts	10
Refuse collection, etc., enquiries and inspections	4
Inspections at school canteens and kitchens, rats and mice infestation	16

School swimming baths visit and sampling of water	1
Meeting with County Analyst re water	1
Visits in connection with the Pharmacy and Poisons Acts	656
Hygiene Lecture at school	1
Testing of detergents at school kitchen	1
Investigation regarding complaint at a Briquette Works	1
Smoke Abatement meetings attended	7
Meetings with Divisional Medical Officers and County District Public Health Inspectors, etc.	82
Ministry of Housing and Local Government Inquiries attended regarding water supplies and sewage schemes	4

Food and Drugs Act, 1955

All County Inspectors of Weights and Measures are appointed Sampling Officers for the purpose of the above Act, and the work of sampling is carried out under the control of the Chief Inspector of Weights and Measures, Mr. J. W. Hopkinson. Details of the work carried out under the Act are referred to in the Annual Report to the County Council of the Public Analyst, Mr. Raymond Mallinder, B.Sc., F.R.I.C., who has kindly consented to its inclusion in this Report:

This has been the first year of operation of the Food and Drugs Act, 1955, which came into effect on 1st January, 1956. The new Act is a consolidating measure, and also provides new powers and definitions; for instance the differences between "cream", "reconstituted cream" and "imitation cream" are now made clear.

The Regulations under the previous Act governing the composition of Foods are retained. Public Analysts and many butchers and manufacturers are still hoping that Food Standards will shortly be introduced to define the meat content of sausages and certain other foods.

It appears that manufacturers are paying more care to the wording of their labels; some are avoiding possible contradictions of terms such as "Non-alcoholic Ginger Wine" and prefer to use the safer title "Ginger Cordial formerly known as So and So's Non-alcoholic Ginger Wine". No doubt the High Court decision that there is no such thing as "non-brewed vinegar" has had its influence in making this change of name.

An interesting innovation of the 1955 Act is that the person who received the third portion of a sample, i.e. usually the vendor or the manufacturer may obtain a copy of the Public Analyst's Certificate by paying a fee of one shilling. Previously the vendor would normally hear nothing further of a sample which was genuine, and he would have to suppose from this silence that his product was satisfactory.

During the year, 3,963 samples were submitted by your Inspectors under the Food and Drugs Act, 1955, as set out in these main categories:

	Total Samples	*Adulterated or Below Standard*	*Percentage Adulterated or Below Standard*
Milk "Appeal to Cow"	44	—	—
Milk	2,791	146	5·2
Milk in Bottle	5	5	100
Milk, Channel Island	66	1	1·5
Foods and Drugs	1,057	44	4·1
All samples	3,963	196	4·9

The proportion of adulterated or substandard samples is similar to that found by other large Authorities.

The following notes on substandard samples may be of interest:

Butter Sweets.—In order to qualify for the names Butter Snips, Butter Drops, Invalid Butter Toffee, etc., these sweets must contain at least 4 per cent. of Butter Fat. Out of 12 samples, 3 were below standard in this respect.

Cream Soups.—The fat content of Cream of Tomato, Cream of Chicken and such like soups is laid down by a Code of Practice. Only one sample was below standard.

Flour.—On 30th September, The Flour (Composition) Regulations, 1956 came into force. These stipulated the proportion of prepared chalk, iron, Vitamin B and nicotinic acid or nicotinamide which must be added to flour other than wholemeal flour. Two samples examined since the introduction of the Regulations were satisfactory.

Foreign Bodies in Food.—The public are more watchful and ready to report the finding of foreign bodies in food.

The instances brought to light by your Inspectors include:

One sliced brown loaf with stains of dirty oil, probably from a bearing in the mixing or kneading machine.

One sliced white loaf containing the stub of a cigarette; this type of foreign substance is offensive and is on a lower plane than the accidental inclusion of a splinter of clean wood or some other clean fragment.

Milk in Bottles.—Five of these were condemned, three because the insides of the bottle were dirty. Some of the blame for this trouble is upon the consumer who leaves unwashed milk bottles outside to gather dirt and become more difficult to wash. One bottle contained a "milk check" which had obviously been pushed into the empty bottle and had not been dislodged by the washing machine. The other bottle was a half-pint size, full of milk and unopened; inside was wedged a piece of writing paper bearing the pencilled instruction "One pint please".

Labelling.—Reference is made above to the increased awareness of manufacturers and packers in framing the wording of their labels. Out of the hundreds of labels examined, exception was taken to only 4:

One sample of Raspberry Vinegar was low in Acetic Acid.

Two samples of Rice Creamola contained cornflower which was not declared on the label. This ingredient had apparently escaped the notice of the manufacturers, who had used it as a diluent or vehicle for the colouring matter.

One sample of Tea bore the label stating "one spoonful of this tea is equal to two spoonfuls of ordinary large leaf tea". Extensive tests proved that the tea had no extraordinary qualities and that the claim was unjustified and misleading. Prolonged correspondence ensued, and this was submitted to the Ministry of Agriculture, Fisheries and Food who supported our view and advised the firm of packers to delete the claim from their label.

Health Salts.—One sample was found to be deficient in effervescent action; it was clear that the sample had been properly compounded originally but had deteriorated in storage.

Ice-Cream.—Of 58 samples, only one was adversely reported; this was low in fat. The majority of Ice-Cream samples are well above the limits for fat, sugar and non fatty milk solids.

Milk.—This food deserves and receives special attention. Of the 2,791 samples of ordinary milk examined, 146 samples were adulterated or below standard. 31 were adulterated with water and 112 were short of fat, 3 contained extraneous water and were also deficient in fat. The greatest percentage of added water was 23·4 per cent. and the highest deficiency in fat was 49·3 per cent.

Channel Islands Milk.—66 samples were analysed and only one contained less than the required 4 per cent. of fat.

Sausages.—Out of 61 samples of *Beef Sausage* six were adversely reported; one contained less than 50 per cent. of meat, the other five contained preservative which had not been declared by label or notice.

Pork and Beef Sausage.—5 samples were submitted, one of which was found to be preserved without proper notice of the fact.

Pork Sausage.—51 samples were tested; 14 contained less than 65 per cent. of meat, 3 others were low in meat and also contained undeclared preservative. In 2 other samples Sulphur Dioxide was found, the presence of which was not declared, and in one of these the amount was excessive, namely 780 parts per million instead of 450 parts per million.

Preservatives.—Most samples are examined for preservatives. This year 8 samples of sausage contained Sulphur Dioxide without proper declaration of the fact. All other samples complied with the Regulations.

Vitamin Preparations.—All the vitamin preparations gave satisfactory assays.

A scheme is in operation whereby the County Council pays the fees of the Public Analyst for all samples of milk taken by Sampling Officers of West Riding County District Councils in accordance with regulations made under the scheme, and also conducts all legal proceedings and defrays all consequential legal expenses. The number of samples of milk submitted for analysis under the scheme in 1956 was 266 of which only 1 was found to be adulterated.

PART VI

OTHER SERVICES

The Welfare of the Epileptic and Spastic

The following are the particulars of known epileptics and spastics:

Adults	*Number* Epileptics	Spastics
1. Provided with accommodation under Part III of the National Assistance Act, 1948:		
(a) in homes for epileptics	56*	
(b) in homes for spastics		5†
(c) in County establishments and establishments where County Council has "right of user"	54	3
2. Registered under the County Council's Scheme of Welfare Services for Handicapped Persons (General Classes)	75	63

*Cookridge Hall Epileptic Home was opened in December, 1955. The County Council was allocated an additional bed during 1956 making a total of 9 beds.

†Several cases awaiting admission to Spastic Homes.

Children

Number ascertained as handicapped:		
(a) Attending ordinary schools	Not known	104
(b) Attending special schools	31	105
(c) Receiving home tuition	3	12
(d) Receiving no education	—	13

The register of handicapped persons, including epileptics and spastics, under the approved scheme has been kept up to date and the information recorded includes the medical classification and assessment of their suitability for employment. Again much thought has been given during the year to furthering the County Council's approved scheme under Sections 29 and 30 of the National Assistance Act, 1948, but owing to the relatively small number of handicapped persons in any one community in the County, the setting up of craft and social centres has not developed considerably during the year. A few centres are being operated through the agency of voluntary organisations in the County Boroughs and these generally serve handicapped persons in the contiguous West Riding areas.

There are now 3 full time handicraft instructresses working in the County. From this agency over 350 handicapped persons were actively engaged in home handicraft work and of this number 35 were epileptics and 22 were spastics.

Again advice to handicapped persons on their various problems and assistance and liaison with other statutory bodies is effected through the 9 Divisional Welfare Officers.

The County Council during the year made grants to organisations providing voluntary services for handicapped persons and grants of £20 and £10 were made to the Huddersfield and District Spastics Society and the newly formed Barnsley and District Epileptic Association respectively.

Local branches of the National Spastics Society are now operating in several districts of the West Riding, at York, Leeds, Bradford, Halifax, Dewsbury, Huddersfield, Barnsley, Sheffield, Pontefract, Castleford and Goole.

A holiday grant of £5 16s. 2d. was made to give an epileptic a holiday at Hornsea Holiday Home and one of £9 to give a very severely disabled spastic a caravan holiday at Morecambe.

Ministry of Health Circular 10/56 together with the report of the Medical Care of Epileptics made by the Sub-Committee of the Minister's Standing Medical Advisory Committee was considered and discussed during the year by official representatives of the School Health and Mental Health and After-Care sections of the Health Department and the County Welfare Officer.

Certification and Treatment of Blind and Partially Sighted Persons

The following table gives particulars of new registrations during 1956 of blind and partially sighted persons (other than handicapped school children):

	Disability (B.—Blind, P.S.—Partially Sighted)									
	Cataract		Glaucoma		Retrolental Fibroplasia		Others		Total	
(i) No. of cases registered during the year in respect of which Section F recommends:	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.
(a) No treatment	95*	29x	11	2	1	2	58	21	185	54
(b) Treatment (medical, surgical, optical or hospital supervision)..	118†	64‡	25	10	—	—	53	52	196	126
(ii) No. of cases at (i) (b) above which received treatment	53§	48o	19	9	—	—	37	42	109	99

* Includes 12 cases of cataract with glaucoma.
x ,, 3 ,, ,, ,, ,, ,,
† ,, 23 ,, ,, ,, ,, ,,
‡ ,, 10 ,, ,, ,, ,, ,,
§ ,, 16 ,, ,, ,, ,, ,,
o ,, 8 ,, ,, ,, ,, ,,

Residential Accommodation

(*National Assistance Act*, 1948)

Under the scheme for residential accommodation the County Medical Officer is responsible for the general medical oversight of the following:

Establishment	*Superintendent/Matron*	*Telephone Number*	*No. of Residents*	
			Men	*Women*
The Shroggs, Skipton Road, Steeton	Miss M. Sedgwick	Steeton 3213	—	20
Farfield Hall, Bolton Road, Addingham	Mrs. A. G. Turner	Addingham 224	13	17
Sharow View, Allhallowgate, Ripon	Mr. and Mrs. E. Brook	Ripon 238	41	30
The Beeches, Leeds Road, Tadcaster	Mr. and Mrs. H. Wright	Tadcaster 2113	69	37
*11 Stockwell Road, Knaresborough	Miss W. M. Brown (Matron) Mr. A. P. Hughes (Sec.)	Knaresborough 2283	50	25
Wharfedale Lawn, Westgate, Wetherby	Mrs. K. Turnill	Wetherby 446	—	23
The Grove, 80 High Street, Starbeck	Mrs. H. Johnson	Harrogate 83980	—	19
Hillworth Lodge, Oakworth Road, Keighley	Mr. and Mrs. P. Rawlin	Keighley 4014	73	129
Thornton View, Thornton View Road, Pasture Lane, Clayton, Bradford	Mr. and Mrs. W. S. Lawson	Queensbury 2007/8	100	100
Woodville, Spring Gardens Lane, Keighley	Miss K. M. Parker	Keighley 2428	9	11
Crow Trees, Leeds Road, Rawdon	Miss A. Earnshaw	Rawdon 908	—	20
Burley Hall, Burley-in-Wharfedale	Miss E. S. Atkinson	Burley-in-Wharfedale 2334	6	19
†Park House, Bradford				
Glenholme, Green Lane, West Vale, Greetland	Mrs. I. Smith	Elland 2985	20	20
Stoneswood, Oldham Road, Delph	Miss M. G. Murphy	Delph 300	8	12

Establishment	*Superintendent/Matron*	*Telephone Number*	*No. of Residents* *Men*	*Women*
Longlands, Leeds Road, Lightcliffe, near Halifax	Miss A. Dickinson	Halifax 68254	8	12
†Scaitcliffe Hall, Todmorden				
Stanley View, Park Lodge Lane, Wakefield	Mr. and Mrs. W. N. Betts	Wakefield 2188	146	94
Beech Towers, Halifax Road, Staincliffe, near Dewsbury	Mr. and Mrs. F. Thomas	Dewsbury 28	175	127
Walton House, Shay Lane, Walton, near Wakefield	Miss G. Carradice	Wakefield 5242	—	20
Turnsteads, Whitcliffe Road, Cleckheaton	Mrs. M. T. Briggs	Cleckheaton 1544	—	23
Brook Lodge, Brook Street, Selby	Mr. and Mrs. J. Whitworth	Selby 15	63	57
Northgate Lodge, Skinner Lane, Pontefract	Mr. and Mrs. C. Borrill	Pontefract 3351/2	116	64
†Wadworth Hall, Wadworth, near Doncaster				
Netherfields, Sheffield and Halifax Road, Penistone	Mr. and Mrs. H. G. Jenner	Penistone 2144	37	29
Wombwell Grange, Park Street, Wombwell	Miss M. Bakewell	Wombwell 2186	—	17

* County Council have "right of user".

† In course of preparation.

Registration and Inspection of Disabled and Old Persons' Homes

(*National Assistance Act*, 1948)

The under-mentioned premises, which are inspected in conjunction with officers of the Welfare Department, are registered as Disabled and Old Persons' Homes:

	Number of Residents	*Type of Home* **(Part I, II or III)*
Congregation of Sisters of Charity of our Lady of Good and Perpetual Succour, St. Anne's Convent, Burghwallis	21	I
Mrs. Bessie Fox, Moor Lane House, Moor Lane, Gomersal	10	I
Harrogate Old People's Home, 66-68 Cold Bath Road, Harrogate	36	I
Skelldale Housing Society Ltd., Borrage House, Ripon	12	I
Ernest Aycliffe Home for Deaf and Dumb Men, Fulford Grange, Rawdon	30	II
North Regional Association for the Blind, "Oaklands", Huddersfield Road, Holmfirth	30	II
Keighley and District Institute for the Blind, 13-15 Scott Street, Keighley	12	II
Misses Mary Emily and Elizabeth North, The Woodlands, Farrar Lane, Oulton	21	I
Mrs. Evelyn Berry, 23 Ash Mount, Keighley	5	III

	Number of Residents	*Type of Home *(Part I, II or III)*
Methodist Homes for the Aged, "Glen Rosa", Grove Road, Ilkley	32	I
Methodist Homes for the Aged, Berwick Grange, 5 Otley Road, Harrogate	28	I
Highfield Home for the Blind, Soothill Lane, Batley	14	II
Miss Rose Seery, Mayfield, 18 Beech Grove, Harrogate	11	I
Catholic Women's League, Clitherow House, 49 Valley Drive, Harrogate	16	I
Mrs. Bertha Miller, "Greylands", Forest Moor, Knaresborough	6	I
Mrs. Anna F. Schramm, "Moor Top", 43 Harlow Moor Drive, Harrogate	8	I
Mrs. I. Brearley, Haversham Court, Ben Rhydding Road, Ilkley	28	III
Miss A. Fildes and Mr. P. Lowe, "Gledhow", 23 Park Drive, Harrogate	9	I
Mrs. D. Tearse, 78 Kingsley Road, Harrogate	2	I
Gratton Home for Aged Ladies, 11 East View Terrace, Otley	14	I
Mrs. A. C. Shepley, Batley Hall, Upper Batley	10	I
Harrogate Guild of Help (Avondale Trust, Ltd.), "The Avondale", Cold Bath Road, Harrogate	26	I
Mrs. K. D. Clarke, "Newlands", 58 Harlow Moor Drive, Harrogate	3	I
Yorkshire Association for the Care of Cripples, St. George's House, Otley Road, Harrogate	52	II
Mr. William Kneen, The Gables, Norland, Sowerby Bridge	8	I
Mrs. M. Fell, Oakfield, Thwaites Brow, Keighley	5	I
Mrs. B. M. Veall, Lansdown Eventide Home, 46 Kent Road, Harrogate	7	I
Misses R. Bulcock and M. Burrows, Blue Dawn Residential Home, Priestthorpe Lane, Bingley	20	I

	Number of Residents	*Type of Home *(Part I, II or III)*
Mrs. Rhoda Herrington, 6 Lancaster Park Road, Harrogate	3	I
Mrs. Blanche Heal, "Burnlee House", Park Head, Holmfirth	3	I

* Part I —Homes for Old Persons.
Part II —Homes for Disabled Persons.
Part III—Homes for Old and Disabled Persons.

I am indebted to Mr. F. B. Armstrong, County Welfare Officer, for supplying most of the foregoing information in this Part of the Report.

Removal to Suitable Premises of Persons in Need of Care and Attention

Where a person is suffering from a grave chronic disease, or being aged, infirm or physically incapacitated, is living in insanitary conditions and is unable to devote to himself, or herself, and is not receiving from other persons proper care and attention, action can be taken by the Medical Officer of Health to secure the necessary care and attention for such persons. This action is taken under the provisions of Section 47 of the National Assistance Act, 1948, or, in cases of urgency, under the National Assistance (Amendment) Act, 1951.

From the reports of Medical Officers of Health it is clear that these powers are used with the utmost reluctance and only as a last resort after all efforts at persuasion have failed to encourage the persons to take advantage of care and attention voluntarily in a hospital or other suitable place.

It was necessary to remove compulsorily 2 men and 5 women to hospital, and 4 men to accommodation provided under Part III of the National Assistance Act, 1948.

Domiciliary Health Services for the Aged

When the provisions of the National Assistance Bill received consideration early in 1948, the Health Committee expressed the view that, "The Medical Division of the Health Department under this system will, in addition to their present duties, be responsible for the medical services arising under the Bill, with particular reference to the establishment of a complete health service for the rehabilitation of the aged, to which field of work the Committee attach prime importance, as it is felt by them that, with the advance of medical science, much can be done to alleviate the handicaps of old age, thus enabling many patients at present in Institutions to play a useful part in the life of the community".

During the year, concern has been expressed on the growing waiting list for Part III accommodation for aged persons in need of care and attention, in consequence of which I was asked to collaborate with the County Welfare Officer in a review to determine whether or not this demand for accommodation could be reduced by a greater use of the health services, developed as may be necessary to meet the particular situation. In the event separate reports were prepared, that which illustrated the development of the health services for the aged and the associated problems being as follows:

In order to examine whether or not the demand for institutional care of the aged may be reduced by a more effective use of the domiciliary health services or by an augmentation of such services, it is necessary to review what is being done in the light of day to day experience and to draw attention to the obvious deficiencies. For this purpose, the subject has been discussed at a conference of Divisional Medical Officers, each of whom, after any necessary consultation with the field workers in or associated with the domiciliary health services, has submitted his observations on the problem. The replies confirm the importance which has been attached to caring for the aged; they differ in emphasis on particular details but are remarkably unanimous in the view that unless domiciliary services are expanded to a scale which would be economically prohibitive in comparison with residential care, any improvements which might be made in those services would contribute little or nothing to relieving the demand for Part III accommodation.

The care of the aged is a problem to which much attention has been directed in the national and medical Press, and in the reports and other publications of the Ministry of Health. A formidable array of Committees have reviewed different aspects of the problem. One feature is common to all: there is no definition of an aged person nor is there anything more precise than the work and approximations of individual research workers on the extent of need for care amongst the aged. For pension purposes, the ages of 65 for men and 60 for women are adopted but it is certain that only a minute proportion are in need of care before or at those ages. The arbitrary adoption of any age provides pitfalls for the problems of the aged are determined not by birthdays but by the physical and mental well-being of the individual.

In the County administrative area, as elsewhere, the social and medical conditions of the great majority of the aged at present living at home are not known. There are, in all, more than 160,000 men over 65 and women over 60 resident in the area; less than 1 per cent. are in care in large and small Homes as Part III accommodation. The number provided with home helps represents some 3½ per cent. although this rate may

be higher as at times the "case" may represent two old people, and about 10 per cent. are receiving domestic or home nursing care, either spasmodically or over lengthy periods. Thus, in view of the fact that a certain proportion are receiving both home help and home nursing care, it would appear that only about 12½ per cent. are known and cared for by the Medical Officer's Department. Our anxieties might be removed if there were sufficient evidence to suggest that apart from those in chronic sick accommodation, the remaining 140,000 aged people were known to be attending Old People's Welfare Organisations, being visited by such organisations or otherwise well and cared for. Unfortunately, we have no such assurance. Since 1948, a total of 96 persons, mostly aged, have been compulsorily removed from their homes either to hospital or to Part III accommodation under the provisions of the National Assistance Act. In many of these cases, the home conditions were deplorable.

From the overall survey which has been made, there emerge two features of a general nature to which attention should be directed. Of primary concern is the evidence of need for close co-operation to avoid wastage in the domiciliary services. It frequently occurs that a health visitor, home nurse or home help will pay a special visit to an aged person only to find that he or she has been removed to the care of relatives, to hospital or Part III accommodation or has died and this information, in some instances, could have been given so as to prevent the unnecessary visit. The second feature is that the problems of the aged are not confined to those in need of domiciliary or institutional care. There is a clamant demand for residential accommodation from aged people who may or may not suffer from the infirmities of old age and who may be able, to a large extent, to look after themselves but who seek such accommodation because they live:

(a) alone and feel lonely;

(b) with family or relatives and are, or feel, unwanted;

(c) in lodgings and are unhappy.

If these conditions continue despite the efforts of statutory and voluntary organisations, there is little effective help which can be afforded by the domiciliary health services.

In referring to the domiciliary health services, we include the health visiting, home nursing, home helps and related ancillary services provided under the National Health Service Act, 1946, and to the voluntary organisations, some of which have been formed under the stimulus of the National Assistance Act, 1948, but many of much greater antiquity.

Health Visiting

Under the provisions of Section 24 of the National Health Service Act, the County Council employs Health Visitors "for the purpose of giving advice as to the care of young children, persons suffering from illness and expectant or nursing mothers, and as to the measures necessary to prevent the spread of infection".

With a chronic shortage of qualified staff, it has been necessary to recruit some 40 lesser qualified personnel; despite this expedient, we are still some 30 below the necessary establishment of 341. Half the time of a Health Visitor is allocated to school nursing duties under the school health provisions of the Education Act, 1944. The remaining part of her time is available for visiting and for clinic attendance, for immunisation against poliomyelitis and other immunisation sessions, for home help supervision and the many other duties for the prevention of illness and the care and after-care of persons suffering from illness, under Section 28 of the Act. Within these terms of reference, she seeks to undertake such visits as may be necessary to aged persons. The necessity for her visiting aged persons in receipt of home help in order to satisfy the Medical Officer that the work is being done may be time consuming and more frequent than would otherwise be necessary, but it does ensure that the aged person's needs are under continuous review. Where the health visitor is a member of the Committee of the local Old Persons' Club, she can contribute much in the direction of help where needed and can learn of those in need; she generally welcomes this close association and it would be an advantage if this pattern were more universally adopted although obviously the Health Visitor is not in a position to nominate herself. In an area consisting of a number of small communities, even more ambitious visiting has been attempted. The Health Visitor endeavours to include in her visiting list all those aged people who are known to be lonely. "Whilst loneliness is not sickness, it is a predisposing factor to sickness." When voluntary visiting is not being done, "Who is to do it? The Health Visitor of course", is the view expressed by Dr. Main Russell (Division 22—Wortley).

The Health Visitor is made aware of the need for visiting by requests from the aged people or their relatives, by general practitioners, voluntary organisations, friends, neighbours, and even sometimes by rumour. She seeks the co-operation of relatives, friends and neighbours. She enlists the aid of the home help and home nurse; she advises on and emphasises the need for adequate nutrition. Dr. Lyons (Division 19—Todmorden) reports:

> "Many aged persons are indifferent to the lesser of their disabilities and frequently do not consult their doctors about them, thus aggravating the tendency towards a general mental and physical decline. A neglected corn or bunion is sometimes the beginning of a vicious circle in which lack of mobility and isolation lead to malnutrition, feebleness and mental deterioration which, in turn, are conducive to further malnutrition and neglect. A word from the Health Visitor to the general practitioner or medical officer can frequently prevent or delay this chain of events. In this sense the preventive work of the Health Visitor is already contributing towards the reduction of pressure on institutional accommodation".

The increasing demands on the Health Visitor cannot be met without some prejudice to her other duties, primarily that of visiting babies and pre-school children. In some areas, it has been found possible to reduce the extent of child-visiting without detriment, but this is by no means true in all areas. The adjustments which are taking place vary in momentum, but in no circumstances can it be contemplated that Health Visitors can or should undertake routine visiting of the aged; even if unlimited staff were available, the cost would be prohibitive. Emphasis should rather be placed on some reliable system of voluntary visiting to ensure that the health visitor is called upon whenever necessary.

Home Nursing

There continues to be a shortage of home nurses and the staff, although diluted with lesser qualified personnel, is some 40 below the revised establishment despite advertisements and the contributions of a training scheme. The position is further embarrassed by the recent award increasing the nurses' annual holidays from four to five weeks. Little useful purpose is to be served in seeking for any further increase in establishment until the existing vacancies have been taken up.

More than half of the visits by home nurses are to persons aged 65 and over; present staffing suggests that any further increase can be accepted only at the expense of the nursing care required by other patients. It must be appreciated that the care of the aged in their homes constitutes not only the greater part but is by far the heaviest work undertaken by the home nurse. Many of the patients are unable to help themselves and have to be lifted, bathed and toileted. Nevertheless, it is the nurses themselves who are aware that more attention could be given to the aged if they had more time. As it is, their work is restricted to essentials and many express regret at their inability to make the return visits to ensure that the patient remains comfortable. Where, however, the essential nursing care has been attended to, is it reasonable to suggest that we should seek to impose a further demand on the inadequate nursing resources of the country for work for which a high degree of professional training and skill is not necessary?

The suggestion has been made that the home nurses could be relieved of much of this work by the employment of unqualified "nurses", suitable women used to domestic responsibilities who could undertake a lot of the bathing, toilet and bed-making of the elderly patients. The virtues of such improvisation by friends and neighbours would loom as major vices in the event of any mishap occurring during the ministrations of such unqualified personnel employed by the County Council, and it is a resort which could be accepted only in dire circumstances.

Effective use of the home nursing service relieves the demand for residential accommodation, but more particularly for chronic sick accommodation; it is helping a more rapid turn over of geriatric beds; it is certainly being used in many cases in substitution for hospitalisation for patients who should be in hospital. In so far as Part III accommodation is not available for cases requiring nursing care, the home nursing service may alleviate but is not and cannot be a major contribution towards relieving the demand for such accommodation.

There is every indication of the need for further increases in home nursing which will of itself contribute towards the greater care of the aged persons in their homes.

Home Nursing Equipment

Allied to the Home Nursing Service is the help which can be given by the loan of suitable equipment for the patients being nursed in their own homes. These range from beds and mattresses, with lifting poles where necessary, to wheelchairs, bed pans and urinals, bed rests and special items of equipment. The only prescription on the availability of such equipment is the establishment of physical need and there is no evidence to suggest that it is not freely available whenever required to facilitate the home care of the aged.

Home Helps

74 per cent. of the Home Help Service was devoted last year to the care of those aged 65 and over; this represents 493 home helps or one working full-time for approximately 350 aged persons; the average assistance to each aged person was 175 hours, the equivalent of 3½ hours per week. Perhaps the most significant of these figures is that which shows that the needs of 350 aged persons are catered for by the equivalent of one home help working full-time; this is a mean for the County as a whole wherein there are violent fluctuations as may be seen in the following table.

Number of Aged Persons per Home Help	*Divisions*
Under 200	25, 27, 28.
200—250	7, 11, 23, 26, 29, 30.
250—300	2, 13, 22.
300—350	12, 15, 17.
350—400	4, 9, 16, 31.
400—450	18.
450—500	5, 8, 10.
500—550	1, 6, 19.
800—900	3, 20.

This brief summary alone serves to illustrate the complexity of the problem. A home help is provided where necessary and where alternative assistance cannot be provided within the family unit or from friends. Unfortunately the presence of members of the family does not necessarily ensure their help; sons and daughters marry and their housing accommodation is provided in new estates deliberately sited on the periphery of the area thus reducing accessibility; married daughters and daughters-in-law, if with children, are fully occupied, and if without children, are often working and reluctant to suffer a loss of income; there is the human element of refusing assistance when home helps are provided for other aged persons; an appreciation of these factors in no way overshadows the preponderance of cases where family assistance is available and readily given, but their cumulative effect is considerable and is likely to increase. If, therefore, the assumption is made that all areas should move towards the maximum assistance now being given—1 home help to 200 aged persons—a further 300 home helps would be required in the County.

The second factor to be taken into account is the extent of help to be given to the individual aged case. The average of 3½ hours per week represents some 4 to 6 hours weekly per case for the period of need, these 4 to 6 hours often being split into two short periods. There are the exceptional cases which vary from this pattern, but generally the home help attends only for such time as is essential for housework. It would be easy to lengthen

these hours to meet the additional needs of companionship and good neighbourliness, if staff could be recruited, but an increase of 2 hours per week per case would in itself represent the recruitment of a further 300 home helps.

The cumulative effect of these two measures, a relaxation in the demand on family responsibility and an increasing service for the aged, might easily involve an increase in the home help establishment to more than twice the present 700.

The full cost of the home help service is now assessed at 3s. 5d. per hour. It can be stated, therefore, that £1 represents no more than 6½ hours' work after due allowance has been made for the recovery of contributions. If to this cost is added the cost of living of the aged person, it will be seen that any attempt to substitute a whole-time home help service in lieu of residential accommodation would be grossly uneconomic.

Reference has already been made to the demands the Home Help Service make on the health visitors' time, but few Divisional Medical Officers favour the introduction of a new hierarchy of home help supervisors or organisers. Such appointments would add to the cost of the service without adequate compensatory advantages. The recruitment and selection of home helps present difficulties in areas where there is alternative industrial employment, but as a generalisation the home help is making a major contribution towards the care of the aged, and in all areas she is augmenting her duties with voluntary services in her leisure hours, offering companionship and additional help outside her contract of service. With representations from most areas for an increased establishment, the warning note is voiced by Dr. Hynd (Division 25—Barnsley) who reports:

> "I would not encourage the use of home helps in anything other than the heavy household chores; for to give full pay for light duties might well have a demoralising effect on the service. So many home helps do such jobs as shopping and week-end attention to the aged in a voluntary capacity, and by paying home helps for what they now do voluntarily might well destroy this spirit of voluntary service."

In summary, it is doubted that any reasonable use of the Home Help Service will act as a substitute for residential accommodation. The Home Help Service is expanding and an early increase in establishment is essential if the established needs of the aged are to be met with only the minimum amount of necessary assistance.

Sitters-in

The available evidence again suggests that the sitter-in, particularly on night duty, will alleviate the demand for accommodation in chronic sick hospitals; furthermore it would probably reduce the demand for Part III accommodation. With few exceptions, Divisional Medical Officers are reluctant to see such a service introduced by the Local Health Authority.

In addition to limited schemes, such as those of the Kent County Council and the Hull County Borough Council, operated by outside authorities, night sitters-in are available in the County area at Aireborough, and in the Wetherby Division. The service is operated by a local voluntary organisation and a sitter-in, provided either continuously or for the occasional night to relieve the relatives, is paid amounts varying from 7s. 6d. to 15s. 0d. a night, which sum the beneficiary is normally expected to re-imburse although inability to pay is no bar to the service.

The objections to this being a County service are manifold; its creation would inevitably have a snowball effect in consequence of friends and relatives finding convincing reasons why they would be unable to volunteer their help when an alternative service could be provided. The rate of pay would be advanced considerably if County employment were substituted for the present token recognition of quasi-voluntary work, and this would bring forward the questions of assessment, with its attendant difficulties, in every case. An acceptable hourly rate of pay would bring the service into competition with the Home Help Service and would recruit from the latter many who would prefer less arduous employment.

This apparently negative response does not overlook the occasional urgent need which can be provided from the present Home Help Service. It does suggest that there is a need for a more positive approach to the many voluntary organisations which exhibit an interest in the problems of the aged so that a voluntary reserve of sitters-in can be available, and with such financial assistance by the County Council as may be necessary.

Chiropody

An appreciable number of the aged population suffer from foot defects, the majority of which would be relieved by regular chiropody treatment. The results of such treatment would be not only to keep the old people ambulant but it would remove a constant deterrent to participation in many social activities. The physical relief and mental stimulus might indeed remove the need for the residential accommodation in many cases. Chiropody might well be brought in as part of the National Health Service but, the Minister of Health, although recognising the value of the work, continues to resist all efforts to extend the service in this way during the present period of financial stringency.

Many local organisations in the County are financing chiropody services for the aged, but these are of a limited nature and do not cover the whole of the area. If this valuable work is to be continued by these voluntary organisations, every encouragement should be given to such organisations to extend this type of service.

Laundry Service

Where aged persons are unable to undertake their own laundry, it is done by the family, friends or neighbours, by commercial laundry or by the home help. For those unable to meet the cost of a commercial laundry, an allowance is paid by the National Assistance Board, although the impression is gained that this allowance is not always directed to its intended purpose.

There are incontinent cases which might be discharged from hospital or detained at home for a longer period before admission if adequate laundry arrangements could be made, but this raises difficulties with commercial laundries and there are many homes without a sufficient stock of bed linen for the purpose. The home help often finds that the washing equipment in a home is primitive and the work is, in consequence, arduous and distasteful. These and other considerations suggest that a domiciliary laundry service would be of benefit to the aged. In one area of the County, arrangements have been made whereby the local "Bendix" depot will wash old people's clothes, an average bundle of 9 lb., for 1s. 6d. In a neighbouring area, a manufacturer offered to supply a modern washing machine at cost price, but the local voluntary committee felt unable to finance the employment of a woman to do the washing. Home helps possessing modern laundry equipment have suggested taking the washing home, but can only be paid for this service if they remain at the house and try to do the washing with little or no equipment and within the allotted time.

It is felt that the cost of using commercial laundries or of providing a mobile laundry service would be prohibitive, but the examples given show that much could be done through voluntary organisations. A further contribution might be to permit the payment to the home help of an additional one or two hours' pay weekly (one for normal and two for incontinent or foul laundry) when taking the laundry home. The objection to this latter scheme would be in many cases the transfer of the financial aspect from the Exchequer to the Local Health Authority whereas the voluntary organisations could continue to collect the National Assistance allowance.

Cleanliness

The difficulties of physical disability and, in some cases, the absence of a good supply of hot water engender an apathy towards regular bathing; the sequence of social unacceptability and general neglect is almost inevitable and it would be of great help if facility for regular bathing were provided and used. The bathing of the elderly features largely in the home nurse's work, but the majority of the aged living at home are not under her care. Here again, the disadvantages of arranging a County service are obvious, but there is much scope for local organisations. The infirm who otherwise have the facilities, require help which need not be of a skilled professional worker. Here is a sphere in which the service of voluntary organisations may be of help, particularly the St. John Ambulance Brigade. Arrangements might be made to use the bathing facilities provided by local authorities, at local hospitals or other residential establishments. It must be recognised that great care will need to be taken in the method of approach to the aged, many of whom might resent any imputation, however justified, against their personal cleanliness.

Nutrition

The aged person living alone often has little inclination to prepare an adequate meal, and amongst this group of the population there is abundant evidence of varying degrees of malnutrition. The "meals on wheels" service which operates in some parts of the area does much to mitigate this condition; unfortunately, this service is not universal; in some areas it has died through lack of volunteers or of demand, and generally only one or two meals are provided weekly. In one area, the Old People's Welfare Committee makes payments to neighbours who do the cooking. Many of the home helps include the cooking of a main meal in their routine duties for the aged, where the allotted time permits and coincides with a meal time. Disquiet is caused by the knowledge that these combined efforts touch but a fringe of the problem. The most attractive solution is that of the good neighbour which, if applied more generally, might stimulate a greater community interest, and might be used to relieve the demands on the home help service. Payment would have to be made to the neighbour and, here again, some degree of financial support would be necessary.

Voluntary Organisations

Many are the voluntary organisations which contribute in one way or another towards the well-being of the aged; from Old People's Welfare Committees under their various guises, Women's Institutes, St. John Ambulance Brigade, Nursing Associations and associated charities, many with a defined boundary, Rotary Clubs and the like. There remains a feeling that much of this valuable energy may be being dispersed through overlapping and that the resources would be the better used if co-ordinated and canalised through one agency. The difficulties are not unappreciated, but every effort ought to be made to this end.

Charitable organisations with capital assets in many instances have the mistaken impression that bankruptcy is a necessary precursor to financial assistance being granted by the County Council and are reluctant first to submit their accounts for examination and secondly to inaugurate new schemes which they are unable to finance wholly; of the subjects under discussion, services for chiropody, sitters-in, home meals, etc., are notable instances.

Summary

The re-deployment of the existing domiciliary services can contribute little towards reducing the need for Part III accommodation. Even if the combined resources of the Local Health Authority and the voluntary organisations were unlimited, there will still be a residue of cases which cannot be catered for adequately at home and for whom Part III accommodation will still be required.

The effective use of the domiciliary services, expanded and augmented as has been indicated, can do much to make the lives of the aged, and particularly the lonely aged, less exacting in the later years and, so far as resources permit, should be pursued. There is need to re-vitalise the spirit of service and there is need for the closest possible co-operation between the various agencies. The interrelation of health and welfare is an obvious indication of this need involving the Welfare and Medical Officer's Departments, the general practitioner and the hospital and consultant services, district councils—particularly in their sphere as housing authorities—the National Assistance Board and the many voluntary organisations.

This combined effort is to be measured not by its immediate results but by the contribution it makes as a preventive measure in ensuring that no aged person is allowed unnecessarily to deteriorate into such physical, mental or social condition as to require residential accommodation. With the spectre of an increasing proportion of the population entering the "aged" group, there is an urgent necessity to stay the process of deterioration; reasonable expenditure to that end might well be regarded as an insurance against an increased liability in the future.

Registration of Nursing Homes

(*Public Health Act*, 1936, *Sections* 187-195)

There were five new registrations and one cancellation of registration during the year, at the end of which forty-one Homes were registered providing forty-six beds for maternity and three hundred and seventy-eight beds for other cases. Forty-two visits of inspection were carried out during the year. The accompanying schedule gives brief details of the nursing homes in the area on 31st December.

Name and Address of Nursing Home	No. of Beds Registered		Types of Nursing Provided					Other Information
	Maternity	Other	General Medical	General Surgical	Obstetric	Psychiatric	Geriatric	
Brooklands Nursing Home, Long Preston	3	7	—	—	Yes	—	Yes	Does not take regular midwifery but takes occasional cases
Sunnybank Nursing Home, Braithwaite, Keighley	—	6	Yes	—	—	—	—	—
The Nursing Home, 58 Devonshire Street, Keighley	—	5	Yes	—	—	—	—	—
Ivy Bank Nursing Home, 162 Highfield Lane, Keighley	—	3	Yes	—	—	—	—	—
Thornfield Nursing Home, Micklethwaite, near Bingley	7	4	Yes	—	Yes	—	—	—
Elmhurst Nursing Home, Hall Bank Drive, Bingley	—	6	—	—	—	—	Yes	—
Farfield Rest Home, 29 Farfield Road, Shipley	—	6	—	—	—	—	Yes	—
Blue Dawn Nursing Home, Priestthorpe Lane, Bingley	12	12	Yes	Yes	Yes	—	Yes	—
Jesmond Nursing Home, New Street, Farsley, near Leeds	—	12	Yes	—	—	—	Yes	—
St. Catherine's Nursing and Rest Home, Leeds Road, Horsforth, near Leeds	—	17	Yes	—	—	—	Yes	Generally hospital convalescent cases
The Hawthorns Nursing Home, Outwood Lane, Horsforth, Leeds	—	16	Yes	Yes	—	—	Yes	Generally hospital convalescent cases
St. Joseph's Convalescent Home, Outwood Lane, Horsforth, Leeds	—	16	Yes	Yes	—	—	—	Generally hospital convalescent cases
Brooklands Nursing Home, Harper Lane, Yeadon, Leeds	—	7	Yes	—	—	—	Yes	—
Westleigh Nursing Home, Pool-in-Wharfedale, near Leeds	—	4	—	—	—	—	Yes	—
Fairholme Nursing Home, Ilkley	—	14	Yes	Yes	—	—	Yes	—
Chevin Hall Nursing Home, Otley	—	24	Yes	—	—	Yes	Yes	—
Clova Nursing Home, Clotherholme Road, Ripon	—	10	Yes	—	—	—	—	—
Ure Lodge Nursing Home, Ure Bank Terrace, Ripon	—	21	Yes	—	—	—	—	—
Staffa Nursing Home, 5 Coppice Drive, Harrogate	3	3	—	—	Yes	—	—	—
Cavendish Nursing Home, 17 Cavendish Avenue, Harrogate	—	7	Yes	—	—	—	Yes	—

Name and Address of Nursing Home	No. of Beds Registered		Types of Nursing Provided					Other Information
	Maternity	Other	General Medical	General Surgical	Obstetric	Psychiatric	Geriatric	
Cavendish Nursing Home, 7 Cavendish Avenue, Harrogate	—	7	Yes	—	—	—	Yes	—
Chelmsford Nursing Home, 9 Rutland Road, Harrogate	—	3	Yes	—	—	—	Yes	—
Alexandra Nursing Home, 7 Alexandra Road, Harrogate	—	8	Yes	—	—	—	Yes	—
Alderson Nursing Home, 2 Alderson Square, Harrogate	—	6	Yes	—	—	—	Yes	—
Duchy House Clinic, 9 Queen's Road, Harrogate	—	22	Yes	Yes	Yes	—	Yes	Operating theatre, X-Rays, pathological investigations
Templestowe Nursing Home, 8 Langcliffe Avenue, Harrogate	—	10	Yes	—	—	—	Yes	—
Ellerslie Nursing Home, 26 Ripon Road, Harrogate	—	7	Yes	—	—	—	Yes	—
Imperial Nursing Home, 29 Rutland Road, Harrogate	6	12	Yes	Yes	Yes	—	Yes	Operating theatre
Nursing Home, 2 East Park Road, Harrogate	—	2	—	—	—	—	Yes	No further admissions to be made
Windermere Nursing Home, 1a Westcliffe Grove, Harrogate	2	—	—	—	Yes	—	—	—
The Pines Nursing Home, 57 Harlow Moor Drive, Harrogate	—	5	Yes	—	—	—	Yes	—
Norman Lodge Nursing Home, 58 Kent Road, Harrogate	—	22	Yes	—	—	—	Yes	—
Beech Grove Nursing Home, 1 Beech Grove, Harrogate	—	8	Yes	—	—	—	Yes	—
Litchdon Nursing Home, 1 East Parade, Harrogate	—	8	Yes	—	—	—	Yes	—
Abbey Garth Nursing Home, 28 Abbey Road, Knaresborough	—	5	Yes	—	—	—	Yes	—
Benton Nursing Home, Benton Hill, Horbury	6	—	—	—	Yes	—	—	—
Bright's Cottage Nursing Home, St. James' Street, Heckmondwike	6	2	Yes	—	Yes	—	—	—
Cross Brook Nursing Home, Todmorden	1	7	—	—	Yes	—	Yes	—
White Windows (West Riding Cheshire Home), Sowerby Bridge	—	30	Yes	—	—	—	Yes	—
Woodend Nursing Home, Atherton Street, Springhead	—	12	Yes	—	—	—	Yes	—
Glenhaven Nursing Home, 35 Cusworth Lane, Sprotborough, near Doncaster	—	2	Yes	—	—	—	—	—

Notification of Births

(*Public Health Act*, 1936, *Section* 203).

"203.—(1) *In the case of every child born it shall be the duty of the father of the child, if at the time of the birth he is actually residing on the premises where the birth takes place, and of any person in attendance upon the mother at the time of, or within six hours after, the birth, to give notice of the birth in manner provided by this section to the medical officer of health of the welfare authority for the area in which the birth takes place.*"

This Section, repeating the provisions of the Notification of Births Acts, 1907 and 1915, is designed to ensure that any services provided by the local health authority for the care of young children shall be made available at the earliest possible moment after the birth of a child; it is more immediate than and additional to the requirement that every birth shall be registered with the local registrar of births within six weeks of the date of birth. There is, however, close co-operation with the local registrars to ensure that all notified births are duly registered and, in reverse, to check on the notification of all registered births. Despite the two statutory requirements, discrepancies are not unusual; indeed, the past year is the first year in which the total number of births notified, after adjustment for inward and outward transfers, has corresponded with the total of 27,093 registered live and still births.

Upon receipt of a certificate of birth, details are passed to the local health visitor who then arranges to make a "first visit" to the new baby. The total of 25,983 "first visits" by the health visiting staff represents 98 per cent. of the 26,469 notified live births.

Failure to register a birth in the past is sometimes revealed at school, at work, at marriage, or when proposing to emigrate. It is then necessary to obtain proof of birth and it is not unusual for reference to be made to the Notification of Births Registers.

Nurseries and Child-Minders Regulation Act, 1948

One private day nursery was registered during the year; two applicants were registered as child-minders and two registrations were cancelled. At the end of the year, there were five nurseries registered for the care of two-hundred-and-four children and five child-minders registered to care for a total of not more than twenty-four children.

Medical Arrangements for County Children's Homes and Residential Nurseries

Divisional Medical Officers have submitted periodic reports on their discharge of their responsibilities for the medical arrangements at County Children's Homes and Nurseries; these provide for the medical examination of children on admission and discharge, subsequent routine and special examinations, the keeping of medical records, precautions against the spread of infectious disease, hours of rest and sleep, the general supervision of health, hygiene and dietary, and the staffing of the nurseries. Routine examinations are undertaken monthly in residential nurseries and every six months in children's homes. The reports reveal the usual childish maladies and infectious disease, the only outbreak of significance being one of Sonne dysentery amongst children who had lately returned from a holiday camp to the children's home. The outbreak was brought under control and a careful review of the staff, food and other hygiene arrangements did not reveal any cause for criticism.

Medical Examination for Superannuation

An appointment to a superannuable post is subject to the applicant passing a medical examination. The examinations are carried out by Medical Officers on the County Council's staff except where the successful candidate resides far outside the geographical County when arrangements are made either for examination by another Local Authority on a reciprocal basis or by a medical practitioner, the fee of 25s. in the latter case being paid by the County Council. In cases where the medical certificate proves inconclusive a specialist's opinion is obtained at the expense of the County Council and the findings are made available to the family doctor.

During the year 1,245 persons were medically examined as set out in the table below and of these 70 were not considered medically suitable for admission to the Superannuation Scheme.

Examined by County Council Medical Officers	1184
Examined by Medical Officers of other Local Authorities ..	19
Examined by General Medical Practitioners .. .. .. (Fee of 25s. payable by the County Council)	42

In 35 cases a Specialist's opinion was obtained.

In addition 52 Special Medical Examinations were arranged at the request of employing Departments and 24 medical examinations were undertaken at the request of other Local Authorities.

PART VII

THE HEALTH OF THE SCHOOL CHILD

(Being the 49th Annual Report of the Principal School Medical Officer)

Introduction

The following pages give an account of the work which has been done during the year by the staff of the School Health Service, whose constant aim is to prevent ill-health, where possible, by the early detection of defects and to promote better health in the children attending maintained schools so that every child can profit to the full from the Education Services which are provided, in the well-known words of the Education Act, "according to his age, ability and aptitude".

The year has not been marked by any spectacular event and there have been no major changes in the nature and character of the Service. The general standard of health remains high and although a continuing high level of economic prosperity amongst the people may be regarded as one of the principal reasons, the parts played by the staff of the School Health Service and the teachers, along with improvements to school buildings resulting in improved hygiene, must take equal credit.

A few features of work of the Service during the year are worthy of note. A considerable proportion of the time of the school medical officers is taken up with routine medical examinations in the schools, and there is a tendency in some quarters to question the value of undertaking the medical examination of large numbers of apparently normal, healthy children. This aspect is discussed in the first section of this Report.

The Child Guidance Service has, for the first time, functioned through the whole year, with a full team of psychiatrist, psychologist and psychiatric social worker, with regular weekly clinics at Wakefield, Shipley and Mirfield. The demands upon this Service are so great, however, and the waiting lists so formidable, that the need to expand remains pressing. National shortages of trained child psychiatrists and psychiatric social workers prevent any rapid development. A welcome addition to the staff was the appointment of a whole-time psychiatric social worker, who took up duties in October. In the same month it was found possible to start a service in the south of the County with the appointment by the Sheffield Regional Hospital Board of Dr. J. D. Orme, psychiatrist, who is now undertaking a weekly clinic at Rawmarsh and also acts as visiting psychiatrist to the Hoober House Hostel.

The staff of school medical officers has remained fairly constant throughout the year. It is with regret that I report the sudden and tragic death of Dr. E. M. Whitehead, who had been on the staff since 1948.

The Report contains an account of a week-end course held for the school medical officers at Grantley Hall, in May, on the Deaf Child. This course was much appreciated by the school medical officers and will prove of great benefit in their work. It has also emphasised a major difficulty encountered by school medical officers working for such a large administrative area as the West Riding County Council which, I feel, is not yet fully appreciated by all concerned. Owing to the size of the County it is not possible for school medical officers to meet sufficiently frequently to discuss their problems and exchange views. Not only does the nature of their work demand a very high standard of up-to-date clinical medicine, but the many rapid advances in recent years which have been made in all branches of medicine and surgery make it essential for the school medical officers to keep abreast of the times. There are medical meetings held throughout the County by Medical Societies, but, unfortunately, these meetings occasionally occur in working hours. While I am grateful for the approval given to school medical officers to attend a hospital on one half-day per week, I feel that the granting of leave of absence with pay for the purposes of attending refresher courses or occasional meetings of outstanding clinical interest could be extended with advantage to the School Health Service. The preventive nature of the school medical officers' work lacks the thrill of curative medicine and makes it all the more necessary to keep alive in the school medical officer a very keen interest in all aspects of medicine.

In conclusion, I wish to pay a tribute to the work of Dr. Marshall, Senior Medical Officer, who has been largely responsible for the compilation of this Report; to all members of the staff of the School Health Service; to the Chief Education Officer and his colleagues; and, finally, to the teachers for their co-operation and patient understanding in the many interruptions to class teaching which are caused by the work of the School Health Service in the interests of "The Health of the School Child".

The Medical Inspection of School Children

The number of pupils on the registers is as follows:—

	Boys	*Girls*	*Total*
Nursery	247	264	511
Primary (County)	68,081	64,566	132,647
Primary (Voluntary)	24,017	22,615	46,632
Secondary Modern (County)	27,772	25,662	53,434
Secondary Modern (Voluntary)	841	1,146	1,987
Secondary Grammar	12,294	12,650	24,944
Secondary Technical	1,288	1,042	2,330
Comprehensive	986	969	1,955
Special Schools	501	359	860
	136,027	129,273	265,300

89,564 periodic medical inspections and 34,021 special inspections and re-examinations were made during the year, compared with 87,520 and 35,296 for the year 1955. Children receive an examination on four occasions during school life, namely, on entry for the first time to school, during the year in which the age of 8 years is attained, in the last year at a primary school, or, alternatively, as soon as possible after entry to a secondary school, and during the last year at a secondary school. The total of 89,564 inspections would appear to indicate, therefore, that the vast majority of the 265,300 children in maintained schools who were due for examination during the year were dealt with.

It is pleasing to note that the number of examinations in the 7–8-year-old category increased from 18,971 in 1955 to 21,980 in 1956. Whatever opinions may be expressed regarding the value of routine medical inspections generally, there is no doubt as to the value of an examination about eight years of age. This is an age when many defects first become apparent—defects of vision, hearing, the first signs of educational sub-normality or maladjustment—and it is much easier, and of great benefit to the child, to combat these defects at the outset.

During the past year there appears to have been a tendency in some quarters to the view that the work of the School Health Service could be done as well, if not better, by general practitioners instead of full-time school medical officers. Closer co-operation could, and should, be possible between family doctors and school medical officers, but it is difficult to see how general practitioners, engrossed as they are by acute illnesses necessitating treatment which is often dramatic in its results, could, at the same time feel as intensely interested in the preventive aspects of illness and in the many minor deviations from the normal which bulk so largely in the work of the school doctor. The time factor would be another aspect of the general practitioners' difficulty in coping with the School Health Service, if such an idea came to be accepted.

The routine medical inspection of school children at fixed times during their school life has many detractors, but it is difficult to envisage any other means of testing satisfactorily the health and well-being of school children otherwise than by at least three routine school medical inspections—at the child's entrance to school, between 7 and 8 years of age, and on leaving school—this would omit the routine school medical inspection which is normally carried out either just before the child leaves the primary school or just after it enters the secondary school. To compensate for the missed examination around 11 years of age, a system could be devised of visiting the schools at regular intervals and discussing any cases causing doubt or anxiety to teachers, parents, or school nurses, but I consider it would be a pity to abolish completely the routine medical inspection. Such inspections give an unrivalled opportunity for school medical officer, teacher, parent, and school nurse to get together on the problem of the health of the school child and his future well-being.

The following tables give details of the numbers of medical inspections made in the various age groups, the number found to require treatment, and the number treated:—

Table I

Medical Inspection of Pupils attending Maintained Primary and Secondary Schools (including Special Schools)

A.—Periodic Medical Inspections

Age groups inspected and number of pupils examined in each.

Entrants	24,659
7 to 8 year group	21,980
Last year primary	12,691
First year secondary	9,514
Last year secondary	17,467
Total	86,311
Additional Periodic Inspections	3,253
Grand Total	89,564

B.—Other Inspections

Number of Special Inspections	22,522
Number of Re-inspections	11,499
Total	34,021

C.—Pupils Found to Require Treatment

Number of individual pupils found at Periodic Medical Inspection to require treatment (excluding Dental Diseases and Infestation with Vermin).

Group (1)	For defective vision excluding squint (2)	For any of the other conditions recorded in Table III (3)	Total Individual Pupils (4)
Entrants	389	3,058	3,357
7 to 8 year group	1,017	2,087	2,981
Last year primary	709	1,121	1,723
First year secondary	578	702	1,230
Last year secondary	1,067	1,300	2,280
Total	3,760	8,268	11,571
Additional Periodic Inspections	160	280	422
Grand Total	3,920	8,548	11,993

D.—Classification of the Physical Condition of Pupils inspected in the Age Groups recorded in Table I.A.

Age Groups Inspected (1)	Number of Pupils Inspected (2)	Satisfactory		Unsatisfactory	
		No. (3)	% of Col. 2 (4)	No. (5)	% of Col. 2 (6)
Entrants	24,659	23,978	97·24	681	2·76
7 to 8 year group	21,980	21,430	97·50	550	2·50
Last year primary	12,691	12,305	96·96	386	3·04
First year secondary	9,514	9,424	99·05	90	0·95
Last year secondary	17,467	17,010	97·38	457	2·62
Additional periodic inspections	3,253	3,171	97·48	82	2·52
Total	89,564	87,318	97·49	2,246	2·51

Table II

Infestation with Vermin

(i)	Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	512,868
(ii)	Total number of *individual* pupils found to be infested	10,379
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	144
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944)	14

Table III

DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31ST DECEMBER, 1956

Note.—*All* defects noted at medical inspection as requiring treatment are included in this table, *whether or not this treatment was begun before the date of the inspection.*

Defect Code No.	Defect or Disease	PERIODIC INSPECTIONS						SPECIAL INSPECTIONS	
		Entrants		Leavers		TOTAL (including all other periodic age groups inspected)			
		Requiring Treatment	Requiring Observation	Requiring Treatment	Requiring Observation	Requiring Treatment	Requiring Observation	Requiring Treatment	Requiring Observation
4	Skin	355	300	315	193	1,211	999	804	292
5	Eyes—a. Vision	391	558	1,077	1,740	3,920	6,350	1,053	2,363
	b. Squint	305	426	42	87	583	1,108	119	305
	c. Other	70	58	33	90	240	289	156	51
6	Ears—a. Hearing	54	206	29	79	196	695	83	188
	b. Otitis Media	106	210	51	89	300	638	107	240
	c. Other	85	77	66	30	228	232	84	68
7	Nose and Throat	858	1,923	194	188	1,736	4,328	480	1,231
8	Speech	137	368	19	23	321	631	233	241
9	Lymphatic Glands	49	711	11	175	93	1,878	39	366
10	Heart	32	302	29	199	134	938	37	356
11	Lungs	155	770	30	178	330	1,750	159	573
12	Developmental—a. Hernia	39	116	8	12	81	217	11	64
	b. Other	32	315	19	37	133	831	40	302
13	Orthopaedic—a. Posture	49	93	126	75	477	539	67	117
	b. Feet	278	358	212	248	1,035	1,273	284	347
	c. Other	189	609	73	258	526	1,728	257	435
14	Nervous System—a. Epilepsy	17	40	15	23	71	133	22	54
	b. Other	67	112	12	25	148	354	50	102
15	Psychological—								
	a. Development	14	93	8	43	71	540	219	289
	b. Stability	25	153	5	84	83	664	34	162
16	Abdomen	7	33	6	20	40	121	9	37
17	Other	488	162	198	122	1,458	690	1,309	388

Table IV

Treatment of Pupils

NOTES

(a) Treatment provided by the Authority includes all defects treated or under treatment during the year by the Authority's own staff, however brought to the Authority's notice, i.e., whether by periodic inspection, special inspection, or otherwise, during the year in question or previously.

(b) Treatment provided otherwise than by the Authority includes all treatment known by the Authority to have been so provided, including treatment undertaken in school clinics by the Regional Hospital Board.

GROUP 1—EYE DISEASES, DEFECTIVE VISION AND SQUINT

	Number of cases known to have been dealt with	
	By the Authority	*Otherwise*
External and other, excluding errors of refraction and squint	1,415	184
Errors of refraction (including squint)	—	17,644
Total	1,415	17,828
Number of pupils for whom spectacles were prescribed	—	9,999

GROUP 2—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT

	Number of cases known to have been treated	
	By the Authority	*Otherwise*
Received operative treatment—		
(a) For diseases of the ear	—	57
(b) For adenoids and chronic tonsillitis	—	1,777
(c) For nose and throat conditions	—	96
Received other forms of treatment	1,512	185
Total	1,512	2,115

	By the Authority	*Otherwise*
Total number of pupils in schools who are known to have been provided with hearing aids—		
(a) In 1956	1	25
(b) In previous years	—	64

Group 3—Orthopaedic and Postural Defects

Number of pupils known to have been treated at clinics or out-patient departments	1,056	624

Group 4—Diseases of the Skin (excluding uncleanliness, for which see Table II)

	Number of cases treated or under treatment during the year by the Authority
Ringworm—	
(i) Scalp	9
(ii) Body	46
Scabies	34
Impetigo	980
Other skin diseases	4,786
Total	5,855

Group 5—Child Guidance Treatment

Number of pupils treated at Child Guidance Clinics under arrangements made by the Authority	294

Group 6—Speech Therapy

Number of pupils treated by Speech Therapists under arrangements made by the Authority	1,342

Group 7—Other Treatment Given

(a)	Number of cases of miscellaneous minor ailments treated by the Authority	29,086
(b)	Pupils who received convalescent treatment under School Health Service arrangements	89
(c)	Pupils who received B.C.G. vaccination	6,665
(d)	Other—	
	1. Ultra Violet Light Treatment	1,548
	2. Chiropody	429
	Total (a)—(d)	37,781

Care of the Handicapped Child

The ascertainment of the various types of handicap in childhood still forms a very considerable portion of the school medical officer's work and, as will be readily understood, is a most important duty. The ten categories of handicap as enumerated in the School Health Service and Handicapped Pupils Regulations, 1953, remain unchanged, and where a single well-defined handicap is present, the ascertainment is comparatively simple. Where, however, two or more handicaps co-exist in the same child, it is frequently exceedingly difficult to decide which is the major disability. There are not many special schools which cater for more than one defect, hence the need to decide which is the major disability and make a recommendation accordingly.

Not only is there the difficulty mentioned above, but the recommendation for any form of special educational treatment cannot be, and is not, lightly undertaken by any school medical officer. Not only must the interests of the child, as a child and not as a handicapped child, be very carefully considered, but the often conflicting views of the parents require equal consideration—parents of handicapped children so often tend to over-protect these children, a very natural and understandable attitude, but one which makes the child less fitted to enter the adult community easily—hence a recommendation for special educational treatment, particularly if it involves placement in a boarding special school, must be very tactfully and carefully suggested. It is still necessary to overcome a great amount of ignorance and prejudice shown by parents on the true place in the education field of boarding special schools.

The Authority now possesses boarding special schools for delicate children (2), for educationally sub-normal children (4), and for deaf and educationally sub-normal boys (1) (this is a school without geographical restrictions on the admission of pupils, being one of the two in England which admits boys from all over the country). In addition there are two boarding homes for maladjusted children and two day special schools for junior educationally sub-normal children. One day special school for educationally sub-normal children for the full age range from 7 – 16, at Swinton, South Yorkshire, will be opened in January 1957.

As noted in my previous report, the emphasis in special educational treatment has shifted from boarding to day special schools. This meets the wishes of the majority of parents, but in areas where there is no long-term plan for the provision of day special schools, boarding school placement is the only solution, and in such areas the additional duty devolves on the school medical officer during the examination of an educationally sub-normal pupil to convince the parents against their natural inclinations of the tremendous advantages to be gained by allowing their child to attend a boarding school. There are, however, in all areas, a number of educationally sub-normal children who, because of adverse home conditions, require boarding placement in preference to attendance at a day special school.

All categories of defect require equal care and consideration and it will be readily understood, therefore, how essential it is for the school medical officers to keep themselves up-to-date with the latest advances in medicine and surgery. The only satisfactory way in which this can be achieved is by attendance at refresher courses from time to time.

The number of new ascertainments and re-examinations undertaken by the school medical officers during the year was as follows:—

Category	*No. of Examinations*
Educationally sub-normal	767
Physically handicapped	210
Delicate	194
Deaf	32
Partially deaf	15
Epileptic	19
Speech (requiring special school)	—
Maladjusted (requiring hostel or special school)	47
Blind	6
Partially sighted	18
Double defect	25
Total	1,333

The following table gives details of handicapped pupils and placings in special schools and hostels during the year, and particulars of the number of children in residence in special schools at the end of the year:—

Category	New Ascertainments	New Placings in Special Schools	Total No. attending Special Schools		No. Boarded in Homes or Hostels	No. Attending Independent Schools	No. Awaiting placement in Special Schools	No. receiving Home Tuition
			Day	Boarding				
Blind	7	11	—	52	—	2	8	1
Partially Sighted	17	10	10	46	—	—	18	1
Deaf	23	19	29	153	—	1	10	—
Partially Deaf	7	4	8	34	—	—	6	—
Delicate	82	67	183	86	5	—	17	4
*Physically Handicapped	36	33	12	94	—	6	27	53
Educationally Sub-normal	194	99	184	317	—	18	539	2
Maladjusted	21	27	—	3	44	1	9	—
Epileptic	14	6	—	31	—	—	4	3
Totals	401	276	426	816	49	28	638	64

* Excluding children sent to or awaiting places in Hospital Schools. At the end of the year there were 267 children on the registers of hospital special schools.

The Physically Handicapped Child.—The chief causes of physical defect in childhood, listed in order of numerical preponderance, are cerebral palsy, poliomyelitis, and heart defects. Other causes are the muscular dystrophies, congenital defects and deformities, and blood diseases.

Heart defects come in two classes, congenital and acquired, the latter due to rheumatic heart disease. Rheumatic heart disease now affects fewer children than it did several years ago, so congenital heart lesions are those most commonly encountered, in addition to numerous cases of what can be termed "innocent murmurs". It is no longer the policy of school medical officers to enforce a life of very limited activity on school children found to have a heart murmur of this latter kind. In the case of congenital heart defects, so much is now possible in the field of cardiac surgery that not only is there an increased expectation of life, but there is also every chance of the child's being able, after successful cardiac surgery, to lead a more or less normal existence.

With regard to the crippling defects which follow an attack of paralytic poliomyelitis, there is every hope that these will decrease in number as a result of the vaccination campaign against poliomyelitis. Children who have acquired severe physical defects following an attack of poliomyelitis usually require special educational treatment in a Special School for the Physically Handicapped or in a Hospital Special School.

The children suffering from cerebral palsy form the largest single group amongst the physically handicapped children, and children with this defect are amongst the most difficult to provide with special educational treatment. It is seldom that a child suffering from cerebral palsy presents one single defect, as not only may there be a greater or lesser degree of physical handicap, but there may also be defective vision, defective hearing, defective speech, or no speech at all. In the majority of cases there is some degree of mental retardation. Despite all these difficulties, the majority of educable spastics are receiving education according to their age, ability, and aptitude, whether in schools for the physically handicapped, the deaf, the partially-sighted, the educationally sub-normal, or the delicate. Quite a number of the minor degrees of cerebral palsy are being educated in ordinary schools and a very small number are receiving home tuition.

The most important aspect of cerebral palsy is early diagnosis. This is possible in large areas of the Administrative County where school medical officers also act as medical officer to the Authority's Maternity and Child Welfare Clinics—in such cases the clinic doctor is aware of the provisions for handicapped pupils under the Education Act, 1944, and will, therefore, look upon a backward baby with, as it were, a "preventive eye" to the child's future.

Another important step in this direction would be the establishment of toddler clinics and of pre-school clinics. Not only could cases of cerebral palsy be diagnosed earlier, but also other defects which are now being found for the first time at the initial routine school medical inspection.

Circular 300 of the Ministry of Education on Special Educational Treatment for Physically Handicapped Children was issued in March, 1956, and gave advice on the improvement of the arrangements for the special educational treatment of physically handicapped children.

It is pointed out in this Circular that Local Education Authorities know of all existing cases of physically handicapped children. This is a somewhat sweeping statement, and it is vitally necessary that all the personnel in the Local Health Authority and Local Education Authority Services should pool information on cases of phsyical defect in children coming to their notice. I have in mind particularly cases becoming known to health visitors where the parents do not attend a Local Health Authority clinic or where the doctor at such a clinic is not a full-time Assistant County Medical Officer and School Medical Officer. In this connection, closer co-operation could do much to bring such cases to the attention of the school medical officers so that early consideration might be given to the need or otherwise for special educational treatment. Equally close co-operation with Hospital Authorities is essential.

The Circular goes on to suggest the possibility of making better use of existing day and boarding special schools, and in particular the re-organisation of function between the various schools; for example, by re-allocation of the type of handicap, sex, and age range dealt with in each. With a steadily decreasing demand for places in open-air schools for delicate children, I feel that the category of child admitted to such schools should be reviewed to include some of the less severely handicapped children without in any way imposing an undue strain on the teaching staff.

The Circular suggests that consideration should also be given to improving the services offered within the schools. It is recognised that much might be done to improve the existing services in special schools, especially in regard to physiotherapy and speech therapy, but it must be borne in mind that an adequate provision of physiotherapists in special schools is well-nigh impossible. The supply of trained physiotherapists is much below the demand and they are more easily attracted into the service of the hospitals where, one must admit, the work is much more varied and interesting.

The position with regard to speech therapists is general all over the country. With the possible exception of the South of England, there are just not enough speech therapists in existence to satisfy the demands. While this situation obtains, regard should be had to using the services of speech therapists to the best advantage; for example, speech therapy for a cerebral palsied child is generally of long duration and the results are often disappointing. It would seem, therefore, that the service at present should concentrate on those children who are likely to derive substantial benefit from the treatment.

With regard to the provision of home tuition for physically handicapped children, there will always be a small proportion of children for whom home tuition is the only solution, such children in the main suffering from a condition with a poor or hopeless prognosis.

It was suggested in the Circular that children suffering from cerebral palsy of such a degree that they are unfit to be accommodated either in ordinary day schools or in day or boarding special schools for either physically handicapped or educationally sub-normal children are best accommodated in centres under the control of the Regional Hospital Board with, if necessary, teaching facilities provided

by the Local Education Authority. The establishment of such centres does not appear to be practicable in the West Riding as there would not be a sufficient number of cases of cerebral palsy in any reasonably sized area which could conveniently attend a centre. The joint use of centres established by any of the County Boroughs might merit consideration.

The Circular goes on to state that there are among the more seriously handicapped cerebral palsied children a number whose educability appears to be doubtful, and affirms that such children should be given a trial in a special school, in an independent school, by home tuition, or in a small day unit. There is no doubt that a small proportion of seriously handicapped cerebral palsied children can only have an accurate assessment of their educability made after a period of observation by a trained team of observers, including medical specialists and/or neurologist, teacher of handicapped children (preferably with experience in teaching the educationally sub-normal), psychologist, speech therapist, physiotherapist, and occupational therapist. Fortunately, the proportion of such children is very small, and a reliable estimation of the intelligence of the majority of cerebral palsied children can be arrived at by the examination of the child by the school medical officer and, if necessary, additional testing of the intelligence with the complete battery of performance tests used by the psychologist.

Particulars relating to educable cerebral palsied children in the County are shown below. The figures include children of pre-school age and many who are not so severely handicapped as to need ascertaining officially as handicapped children.

Total No. of educable spastics	No. accommodated in Special Schools	No. attending ordinary schools		No. receiving Home Tuition	No. receiving no education
		Satisfactorily	Needing placement in Special Schools		
224	99*	64	36	12	13

* Accommodated as follows:—

Heritage Craft Schools, Chailey	6
Adela Shaw Orthopaedic Hospital, Kirbymoorside	9
Royd Edge School for Educationally Sub-Normal Children	2
Holly Bank Special School, Huddersfield	19
Exhall Grange, Coventry	4
Field Heath House Special School, Hillingdon	1
Braithwaite Open-Air School, Keighley	1
Nortonthorpe Hall Hostel for Maladjusted Boys, Scissett	1
Bradstock Lockett Hospital School, Southport	2
Hesley Hall, Tickhill	8
Camphill Rudolf Steiner Special School, Thornbury Park	2
Wilfred Pickles' School, Tixover Grange, Duddington	4
Town Hill Park Special School, West End, Southampton	1
Hinwick Hall School, Wellingborough	2
St. Rose's R.C. Special School, Stroud	1
Baliol School for Educationally Sub-normal Pupils	3
St. Chad's School, Prestatyn	1
Springfield School for Educationally Sub-normal Pupils	4
Pinderfields Hospital, Wakefield	1
Etton Pasture School for Educationally Sub-normal Pupils	1
Moorlands Open-Air School, Dewsbury	1
Bethesda Home, Salford	1
National Children's Home, Chipping Norton	3
Brighouse Open-Air School	5
Rob Roy Special School, Oakham	2
Victoria Home Special School, Bournemouth	1
Stile Open-Air School, Todmorden	2
Leasowe Children's Hospital	2
Whiteness Manor, Broadstairs	1
Welburn Hall Special School, Kirbymoorside	1
Wombwell Day School for Educationally Sub-normal Pupils	1
St. Margaret's School, Croydon	1
Lister Lane Day Special School, Bradford	1
Shipley Day School for Educationally Sub-normal Pupils	1
Lingfield School for Epileptics	2
Maghull Home for Epileptics, Maghull, Liverpool	1

The Delicate Child.—This category of handicap is steadily decreasing in numbers, and is now largely made up of children suffering from bronchitis or asthma, with an occasional and rare case of debility. This decrease in numbers is general all over the country and is reflected in the type of case being admitted to some open-air schools—cases of physical handicap now being accepted.

In so far as the Authority's boarding special school at Ingleborough Hall is concerned, it was decided in December, 1956, to lower the age of admission to 6 years and to retain girls, in cases where it was considered advisable, to the age of 13 years.

As I pointed out in my Annual Report for 1955, there are always a number of children, apart from those ascertained as delicate, who require convalescent home treatment for a temporary period, the maximum length of stay being three months. These cases arise either as a result of illness or from unsatisfactory home conditions. It might be administratively possible to send some of these cases into the open-air schools, even if only for a term. During the past year 89 children (the same number as for 1955) were sent to convalescent homes for periods ranging from one to three months.

The children who require boarding special school placement as delicate are admitted either to Ingleborough Hall, Clapham, or Netherside Hall, Skipton. These two schools are visited twice per year by Dr. Harvey, the Consultant Paediatrician, whose advice has proved most useful.

The Blind and Partially Sighted Child—The blind and partially sighted child is always referred to an Ophthalmologist for a full and comprehensive examination, the findings of such an examination being recorded on Form B.D.8. In March 1955 the Ministry of Health issued Circular 4/55 following discussions with the Faculty of Ophthalmologists and the Ministry of Education regarding the standards of examination and certification of applicants for admission to the Register of the Blind or the Register of the Partially Sighted. Although the provisions of Circular 4/55 apply mainly to adults, a number of children up to the age of 16 years are also involved. The Ministry of Education issued Administrative Memorandum No. 493 to Local Education Authorities at the same time. Briefly, the Administrative Memorandum states that any Form B.D.8 completed in respect of a blind or partially sighted child should be the work of an Ophthalmologist of consultant status. The criteria to be adopted in deciding whether a child should be regarded as blind or partially sighted are set out in two appendices to the Memorandum, and the Minister of Education is prepared to accept these criteria as guidance to Ophthalmologists when making recommendations about the special educational treatment of children. But a Local Education Authority, in deciding the form of special educational treatment for a particular child, has also to take into account other considerations, such as the degree of intelligence of the child in question and the extent to which arrangements can be made for his special educational treatment in an ordinary school in the district in which the child lives.

The Deaf and Partially Deaf Child.—The number of deaf pupils requiring special educational treatment has been estimated at 0·7 to 1·0 per 1,000 registered pupils, as is indicated in Pamphlet No. 5 of the Ministry of Education on Special Educational Treatment. At the end of the year there were 193 deaf and 48 partially deaf pupils on the register requiring placement in special schools, of whom 29 deaf and 8 partially deaf were accommodated in day special schools and 154 deaf and 34 partially deaf were placed in boarding special schools, leaving 10 deaf and 6 partially deaf awaiting placement.

It is becoming more widely known that early ascertainment of deafness or partial deafness in childhood is of vital importance to the child's development. Because of this, it was decided to hold a week-end residential course for school medical officers on the "Ascertainment, Training and Education of the Deaf Child" at the Authority's Adult Educational College at Grantley Hall, Ripon, in May 1956.

The Chair at the opening meeting was taken by County Alderman W. M. Hyman, Chairman of the College Governors. The course comprised 7 lectures, the first of which was a talk on special educational treatment given by Mr. L. W. K. Brown, Deputy Education Officer. Mr. Brown gave a general review of special educational treatment in regard to all categories of handicapped pupil, and pointed out administrative difficulties which might not be apparent to examining medical officers in the field.

The second lecture was given by Mr. J. E. Rees, Consultant Ear, Nose and Throat Surgeon, Harrogate General Hospital, and Consultant to the Authority's Special School for Deaf and Educationally Sub-normal Boys at Harewood. Mr. Rees spoke on the Anatomy of the Ear and on diseases causing impaired hearing, as found in young children. He mentioned specifically the condition in which the middle ear fails to develop as a canal and in which the optimum age for operation is 4 years. He also mentioned the effect of German Measles in the early months of pregnancy in the mother, and said that as a result of an outbreak of German Measles in Australia in 1941, German Measles was now notifiable in that country. If it occurs in the second month of pregnancy, 100 per cent. of the children are born deaf, and if in the third month, 50 per cent. of the children are born deaf. An interesting point he made was that congenital syphilis is now rarely found as a cause of deafness in children.

Following on Mr. Rees' lecture was one given by Mr. Michael Reed, M.A., who is the Psychologist attached to the Royal Throat, Nose and Ear Hospital, London, and who works in close co-operation with Miss Whetnall at the Audiology Unit there. The theme of Mr. Reed's talk was the assessment of the intelligence of the deaf child, and he mentioned many tests which were employed. It was clear from this lecture that estimating the intelligence of deaf children is a very highly skilled operation which can only be undertaken if sufficient testing material is available and if the examiner is experienced and familiar with the material.

The next two lectures were given respectively by Mr. W. S. Greenaway, Headmaster of the Yorkshire Residential School for the Deaf, Doncaster, and Mr. A. E. Steel, Headmaster of Bridge House Special School, and were concerned with the education of the deaf children in their respective schools, that is deaf children of normal intelligence and deaf and educationally sub-normal children.

The last two lectures on "The Deaf Child", when the Chair was taken by County Councillor D. A. Crockatt, Chairman of the Divisional, School Health and Dental Services Sub-Committee, were given by Miss Whetnall, F.R.C.S., of the Royal Throat, Nose and Ear Hospital, London, who is internationally known. It has been recognised by aural surgeons for some considerable time that very few children are totally deaf. Most deaf children have some residual hearing, and if this can be stimulated at a very early age such children will learn normal, or nearly normal, speech. Miss Whetnall first of all explained the development of speech in children with normal hearing, in which a period of "readiness to listen" must occur during the first year of life, to be followed, about the age of twelve to eighteen months, by a period of "readiness to speak". Understanding of speech always precedes the production of speech. The ability to recognise the meaning of sounds or of words, known as auditory discrimination, and which is the most important factor in normal hearing, is learnt during the first three years of life. Miss Whetnall is of the opinion that cortical centres in the brain readily learn to discriminate during the first three years of life between auditory stimuli, but after this period learning becomes increasingly difficult. The deaf child, without a hearing aid or training, does not receive sufficient auditory stimuli to learn to make these discriminations. Therefore the deaf child has to have a hearing aid, which must be worn continuously, so that he may hear sounds all the time. A baby of ten months of age has been given a hearing aid, while several children not much older have been given aids. It has been found that a young child likes his aid, wears it all the time, and is upset without it. On the other hand, when a hearing aid is given to an older child, who has not received auditory training in his earliest years, he is often past the age when discrimination can be learned and, to him, all sounds are noises. Another point emphasised by Miss Whetnall is that the congenitally deaf child, whose residual hearing has been untrained, if taught to lip read, seems to become a fixed visualiser and incapable of the ability to listen. There is also the need to enlist the full support of the child's mother and family, who must appreciate what is being done for the child and who must be trained to assist and help the child in every way.

It was obvious from Miss Whetnall's statements that these objects can only be achieved if proper diagnostic facilities exist, such as properly staffed and equipped audiology clinics which deal solely or mainly with the ascertainment and training of the young deaf child. Any centre of this nature can only be successfully established if there is full co-operation and interest on the part of the Regional Hospital Board, the Consultant Ear, Nose and Throat Staff, and the Local Education Authority. Audiology centres must be sited where there are large concentrations of population, for example, County Boroughs. In the West Riding a suitable situation is the Doncaster area, where it might be possible to establish a centre in conjunction with the Yorkshire Residential School for the Deaf.

An Open Forum was held at the conclusion of the course, under the Chairmanship of County Alderman Mrs. J. Smith, Chairman of the Special Services Sub-Committee of the Education Committee. Numerous questions were put which were answered by Miss Whetnall and Mr. Greenaway.

In regard to children attending ordinary schools, school medical officers should be constantly on the alert for signs of deafness, no matter how slight, and then arrange for a detailed assessment of the hearing loss through the Ear, Nose and Throat Consultants. There is a form of deafness in which there is inability to hear high frequency sounds such as the consonants used in speech, and as a result of which the child fails to learn to speak properly. Such children may be suspected of being educationally sub-normal if the possibility of high frequency deafness is overlooked.

In 1949 the County Council agreed to the purchase of two gramophone audiometers for the group testing of large numbers of school children in schools, with a view to improving the facilities for ascertaining deaf children. Since then these audiometers have been used in a number of Divisions, but it has become apparent, from the experience gained, that this method of ascertaining deafness is by no means satisfactory. It is time consuming and, after eliminating other factors such as limited intelligence, poor understanding of what is required in the tests, and having regard to the amount of external noise present to some degree in every school, the only result from the surveys has been to reveal the more obviously deaf children who are already known to the school medical officer. It was therefore recommended to the Committee that two pure-tone audiometers be purchased for use in the schools. Approval to their purchase was granted and the audiometers are expected to be in use in 1957.

The surveys, which will be undertaken in selected areas by the use of the pure-tone audiometers, are not expected to reveal many cases of children who can properly be classified as deaf and who are not already known to the school nurse or school medical officer or teacher. But what can be expected is the discovery of a considerable number of children with hearing loss, the existence of which should be known to the parent and teacher, and which can be relieved or improved by medical treatment, favourable position in the class in the ordinary school and, in some cases, by the provision of a hearing aid or lessons in lip reading. It is not expected that many cases will be discovered of partial deafness for whom special educational treatment in a special school is considered necessary.

In the Report of the Chief Medical Officer of the Ministry of Education for the years 1954–55 on the Health of the School Child, it is strongly emphasised that a child who becomes deaf—usually as a result of meningitis—after he has acquired speech and language in the normal way, should not, if it can be avoided, be educated in a school for the deaf. The definition of partially deaf in the School Health Service and Handicapped Pupils Regulations, 1953, reads: "Partially Deaf Pupils—that is to say, pupils who have some naturally acquired speech and language, but whose hearing is so defective

that they require for their education special arrangements or facilities, though not necessarily all the educational methods used for deaf pupils". This makes it clear that the late deafened fall into the partially deaf category. With the modern highly successful treatment of the various forms of meningitis, many children now recover from the disease, some, unfortunately, at the cost of their hearing, and the hearing loss is usually severe. These children should be admitted to schools for the partially deaf if they cannot remain in the ordinary schools. As soon as deafness is suspected or diagnosed, auditory training and instruction in lip-reading should be commenced, preferably while the child is still in hospital. Cases are reported where, with such early training, the speech has been preserved and the child has succeeded in maintaining satisfactory educational progress in the ordinary school. Without early auditory training, even highly intelligent children admitted to schools for the deaf have lost their speech completely.

Associated closely with the problem of deafness is the condition of otitis media, whether acute or chronic. There has been a marked decrease in the prevalence of chronic otitis media over the past decade due, first of all, to the use of sulphonamides and, later, to antibiotics. The chronically discharging ear, so long the bugbear of the school medical officer, the school nurse and the school teacher, is now a thing of the past. But its disappearance has led to another danger. Frequently at routine school medical inspections the school medical officer has been content to ask the child's parent if he ever had any ear discharge. The reply is usually in the negative due to the fact that prompt treatment with antibiotics by a general practitioner clears the condition up so quickly that neither parent nor child has any recollection. Then, if the school medical officer does not use an electric auriscope at every routine medical inspection, the presence of minute perforations of the eardrum are inevitably missed, owing to the lack of a history of otitis media. Such missed perforations may then be discovered at the medical examination prior to National Service, to the disappointment of the youth who wishes to enter the Armed Forces as a career and to the discomfiture of the school medical officer.

The Epileptic Child.—In "The Health of the School Child" for the years 1954–55, it is stated that probably 1–2 per 1,000 school children either have or have had epileptic seizures other than infantile convulsions, whereas estimates of the prevalence of epilepsy obtained from medical examinations for National Service has been about 5 per 1,000. It is an established fact that mothers tend to conceal any history of fits from school doctors, but it is not assuming too much to state that any incidence of epilepsy is magnified by young people in an attempt to evade National Service.

The Sub-Committee, under the Chairmanship of Sir Henry Cohen, which was set up in June 1954 by the Standing Medical Advisory Committee of the Central Health Service Council, "to review arrangements for the care of epileptics and to make recommendations", published its report in 1956. Among its recommendations affecting the School Health Service are the following:—

(1) Children suffering from epilepsy should, as far as possible, be educated in ordinary schools.

(2) The decision to send a child suffering from epilepsy to a special school should be taken only after assessment at a hospital diagnostic clinic.

(3) The general practitioner should inform the school medical officer of any child with epilepsy who is about to attain school age and is to attend an ordinary school.

(4) When the educational requirements of a child with epilepsy are being assessed, the services of an educational psychologist should be available.

It has been the policy of recent years for this Authority's school medical officers to recommend special educational treatment in boarding special schools only for those epileptic children whose seizures have not been controlled by sedation and whose condition gives rise to anxiety in the teaching staff. In this way quite a number have attended ordinary schools who may have only an occasional seizure.

During 1956, 6 pupils were newly placed in special schools, 3 received home tuition, and 4 were awaiting placement in special schools. The total number of children accommodated in special schools for the epileptic at the end of the year was 31.

The Educationally Sub-normal Child.—In March 1956 a request was received from the Senior Medical Officer, Ministry of Education, to furnish a report on the I.Q. level of children in the Authority's day or boarding special schools for educationally sub-normal children. The report divided the children into categories of I.Q. below 50, 50–59 inclusive, 60–69 inclusive, 70–79 inclusive, and 80 and over. From the returns it was found that out of a total of 326 children in attendance at the Authority's special schools 3 children had an I.Q. below 50, 38 children were between 50 and 59, 123 children were between 60 and 69, 115 children were between 70 and 79, and 47 had an I.Q. of 80 and over. From this list it will be noted that the biggest proportion of children had I.Q. ranges of 60–79, so that they were correctly placed. But it was felt that the wide variations of I.Q. level, ranging as it did from 40 to over 100 in children recommended for special educational treatment in special schools, indicated a degree of confusion amongst school medical officers whose duty it is to ascertain these children. It was also felt that school medical officers and educationists had varying interpretations as to what degree and extent of backwardness constitutes educational sub-normality. Arrangements were therefore made to hold a meeting of school medical officers, and Dr. Weaver, C.B.E., Senior Medical Officer to the Ministry of Education, and Mr. Parnham, H.M. Inspector, were invited to express their views on educational sub-normality. This meeting did a good deal to clarify the views and recommendations of school medical officers.

One very interesting topic discussed at this meeting was the type of child with a normal, or nearly normal, I.Q. whose educational attainments fall far short of his potential. The educationists emphasised the fact that if this type of child is recommended for special educational treatment in a special school for educationally sub-normal children, his potential is so much greater than that of the true educationally sub-normal child that he will find himself out of place in a school for the educationally sub-normal. He should rather be recommended for special educational treatment in the ordinary school and it will then be the responsibility of the Education Service to see that he does get the extra help he requires.

At the end of the year there were 1,060 children on the register stated to require education in special schools, of whom 519 were in day or boarding special schools and 2 receiving home tuition, leaving 539 on the waiting list for admission to day or boarding special schools.

If a child is truly educationally sub-normal, the sooner this fact is recognised the better, so that proper steps can be taken to provide special educational treatment. It is very much easier to place junior educationally sub-normal children in boarding special schools than it was a few years ago, but the emphasis in all forms of special educational treatment in the past few years has shifted from boarding placement to placement in day special schools. In spite of this trend, there will always remain a percentage of educationally sub-normal children who will require boarding special school placement in preference to a day special school, particularly those with bad home backgrounds. Children who are ascertained as educationally sub-normal at 11 years of age and later do not have much chance of being placed in special schools, so it is essential that teachers in junior schools are aware of this in order that they may bring to the notice of the school medical officer any child whom they find is retarded to a greater or lesser degree.

The plans of the Authority to build two all-age day special schools at Cleckheaton and Swinton will help considerably in placing the educationally sub-normal child of senior school age, and it is hoped that the Swinton school will be opened in January 1957. The placement of West Riding children in special schools maintained by County Boroughs also helps to relieve the situation.

During the year 121 children were reported to the Local Health Authority under Section 57 (3) of the Education Act, 1944, as being ineducable and 93 children under Section 57 (5) as requiring supervision after leaving school. It cannot be emphasised too strongly how very much care and attention is given to these children by the school medical officers before recommendations are made that they should be reported as ineducable. Every developmental detail in the child's history is noted as well as a thorough physical examination being carried out and, where, practicable, mental testing as well. It occasionally happens that a child is reported as ineducable at a certain age, but is found, after a period in an occupation centre, to have developed mentally to such a degree that he can be regarded as educable, but he will still require special educational treatment as an educationally sub-normal child. When this occurs the child is re-assessed, de-certified, and given a trial period in a special school for educationally sub-normal children. Such a sequence of events does not mean that the child was wrongly reported in the first instance—no child can be admitted to an occupation centre unless previously reported as ineducable, and a child thus reported will get the benefit of the training in the occupation centre which, as stated earlier, may lead to such mental development as to enable the child to be classified ultimately as educationally sub-normal.

Children with Speech Defects.—Children suffering from speech defects belong to one of the ten categories of handicapped child as enumerated in the School Health Service and Handicapped Pupils Regulations, 1953. Children who suffer with any form of speech defect should be referred to the school medical officer for the area who will, after examination, complete the necessary Medical Report Form and refer the child to the speech therapist. It is essential that there should be the closest co-operation between the school medical officer and the speech therapist, and all cases treated by the speech therapist should be seen in the first instance by the school medical officer. It should not be necessary to emphasise that all children with speech defects should have an assessment made of their hearing.

The treatment of speech defects by trained speech therapists is of comparatively recent origin, and with a view to increasing the knowledge of school medical officers regarding speech therapy it is proposed to hold a residential week-end course during 1957 at which various well-known speech therapists will lecture. An account of this course will appear in the Annual Report for 1957.

At the end of 1956 there were 36 speech therapy clinics in operation. The following table gives details of the work undertaken at the clinics during the year:—

1.	Total number of sessions held during year	2,997
2.	(a) No. of new cases treated during year	545
	(b) No. of cases already attending for treatment from previous year	797
	(c) Total number of cases treated (a + b)	1,342
3.	No. of cases awaiting treatment at end of year	464
4.	No. of visits made to schools	226
5.	No. of home visits	77

Analysis of Defects treated during year

	Boys	Girls	Total
1. Stammering	295	72	367
2. Defects of articulation—			
(a) Dyslalia	446	185	631
(b) Sigmatism	64	51	115
(c) Rhinolalia, due to—			
(i) Cleft Palate	36	12	48
(ii) Nasal Obstruction	8	2	10
(d) Dysarthria	13	7	30
3. Aphasia	1	—	1
4. Defective speech, due to—			
(i) Educational sub-normality	37	21	58
(ii) Deafness	3	6	9
5. Retarded speech development	74	26	100
6. Dysphonia	9	6	15
7. Other Defects	13	10	23

Analysis of cases discharged

No. of children discharged during year:—

1. Speech normal	189	98	287
2. Speech improved	64	35	99
3. Unsuitable for treatment	14	8	22
4. Non-co-operation	40	15	55
5. Left school	9	7	16
6. Left district	20	9	29
7. Observation	2	—	2
8. Other reasons	5	5	10

The Maladjusted Child.—The following pages contain three reports on the work of the Child Guidance Service. There is a report by Dr. Leese on the first full year's working of the three centres at Wakefield, Mirfield, and Shipley; a report by Dr. Orme on the Rawmarsh Centre, which did not open under his direction until October 1956; and a report by Mr. Pickles, the Child Guidance Psychologist, who, in addition to working at all the centres with Dr. Leese and Dr. Orme, has also undertaken work in connection with the Skipton Centre, which has been held less frequently than the others and has been attended by Dr. Burbury from the Leeds University Department of Psychiatry.

Dr. Leese reports as follows on the Mirfield, Shipley, and Wakefield centres:—

Since February 1st, when Mr. D. G. Pickles joined the Child Psychiatric Service as a psychologist, the team has had representatives of each of the three component disciplines—psychiatrist, psychologist, and psychiatric social worker. But until October 1st, when Mr. J. Coulson was appointed as a full-time psychiatric social worker, Mr. Pickles worked in a double capacity at Wakefield. Mr. Coulson works also at the Rawmarsh Centre. Apart from their work on the clinic days, Mrs. Nursten and Mr. Coulson work with the families who have children at the two hostels, Hoober House and Nortonthorpe Hall, and visit the homes in cases where it is inconvenient for the mothers to visit the clinics. Mr. Pickles visits as many schools as possible from which we have children, and discusses their educational problems as well as the wider ones that have prompted their referral to the clinic. In April, Miss D. P. Nettleton joined the staff as a peripatetic secretary, and her competence has greatly helped towards the smooth running of the clinics. The team welcomes the opportunity for liaison with the Probation Officers that arises from their invitation to case conferences. Unfortunately, these have been at times when only Mr. Coulson has been free to go. We hope these invitations will be continued.

The following tables give some details of the work during the year. The types of disturbance are classified as suggested in the Underwood Report on the Maladjusted Child. No form of classification has been devised into which all symptoms can be neatly pigeon-holed. The Underwood Report method was adopted for these records as the one most likely to be popular at present, so that clinics might have a common framework for comparison of statistics. Disturbances have been listed as we found them in the clinic, and not according to the symptom of referral. It is common to find that the symptom of referral is of the greatest nuisance value from the parents' point of view, for example, enuresis, which, on further investigation, may uncover nightmares and pilfering. The symptom total is, therefore, greater than the number of children seen. To prevent a false impression that the figures quoted represent the bulk of children needing psychiatric help in the West Riding, I should like to emphasise that according to the calculations in the Underwood Report of the Committee on Maladjusted Children, a population of 250,000 school age children needs five full psychiatric teams, each consisting of one psychiatrist, two psychologists, and three psychiatric social workers. The West Riding Child Psychiatric Service had, in December 1956, ten-elevenths psychiatrist help (from three psychiatrists), one full-time psychologist, and one and six-elevenths psychiatric social work help. In spite of the Divisional Medical Officer screening the referrals to ensure that only the most seriously disturbed children come to the clinics, the Wakefield waiting list represents about six months' work, and Mirfield and Shipley waiting lists not much less.

Since each clinic is open only one day a week, the original plan was that these should be primarily diagnostic sessions and secondarily treatment sessions. In practice, these three centres have run on much the same lines as other Child Psychiatric Clinics, in which about one-third of the cases are seen for diagnostic purposes only. The individual figures are: Mirfield and Shipley one-fifth to one-quarter approximately, and Wakefield one-third. These differences may well reflect the fact that the preliminary screening by the comparatively few school medical officers referring cases to the Shipley and Mirfield centres results in a greater proportion of cases being taken on for treatment. The Wakefield centre serves a wide area and it is noticeable that a large number of the cases referred present basic social problems which make them unsuitable for treatment. Thus, at Wakefield, there is a higher proportion of cases seen for diagnostic purposes only than at the other two centres.

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In the Spring Term, three post-graduate students studying at The Institute of Education in Leeds, visited the Shipley Clinic on three occasions and the Mirfield Clinic twice. These students were joined by local health visitors at case conferences to illustrate different types of disturbance. In the early part of the Summer Term five meetings were held in Wakefield with the officers in charge of the West Riding Children's Homes. Several children from these 29 Homes had been referred to the clinic and it was felt profitable to meet and discuss problems peculiar to such children. Mr. Stuart, the County Children's Officer, came to the last meeting and helped our understanding of the difficulties that arise on the administrative side. This group was reluctant to disband, so in the Autumn Term we met on three occasions to see films emphasising some problems of childhood and to discuss these afterwards. On these occasions the group was joined by Children's Officers, Probation Officers and Health Visitors. The three films were "A Two Year Old goes to Hospital", "Shyness" and "Family Circles". This type of meeting is to be repeated in 1957.

(A) Cases seen at the Child Guidance Centres during 1956

	Child Guidance Centre									Total		
	Wakefield			Mirfield			Shipley					
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
No. of new cases seen during year	79	35	114	29	18	47	52	16	68	160	69	229
No. of cases continuing attendance from previous year	23	6	29	14	3	17	13	5	18	50	14	64
Total number of cases seen during year	102	41	143	43	21	64	65	21	86	210	83	293
No. of interviews during year—												
(a) Psychiatrist (children and parent(s) on initial visit)	236	92	328	161	64	225	190	47	237	587	203	790
(b) Psychologist (mostly children only)	112	43	155	94	28	122	140	22	162	346	93	439
*(c) Psychiatric social worker (parents only)	169	66	235	179	106	285	372	103	475	720	275	995
Total interviews	517	201	718	434	198	632	702	172	874	1,653	571	2,224
No. of cases recommended and placed for residential treatment in hostels for maladjusted children (Nortonthorpe Hall and Hoober House)	1	1	2	3	3	6	6	1	7	10	5	15
No. of cases continuing treatment into 1957	36	9	45	16	13	29	36	9	45	88	31	119

* The psychologist acted as psychiatric social worker at the Wakefield Centre from the 1st February to the 30th September, 1956, when a whole-time psychiatric social worker was appointed.
The psychologist was still interviewing some parents at the end of the year.

(B) Types of Disturbance as Diagnosed— New Cases

		Wakefield				Mirfield				Shipley				Total			
		Under 5 years	6–10 years	11+	Total	Under 5 years	6–10 years	11+	Total	Under 5 years	6–10 years	11+	Total	Under 5 years	6–10 years	11+	Total
Nervous Disorder	B.	1	11	3	15	1	4	6	11	—	1	4	5	2	16	13	31
	G.	1	4	3	8	—	1	—	1	—	1	2	3	1	6	5	12
Habit Disorder	B.	1	4	5	10	—	3	3	6	—	7	3	10	1	14	11	26
	G.	2	2	1	5	—	3	2	5	—	—	—	—	2	5	3	10
Behaviour Disorder	B.	1	21	15	37	—	9	10	19	—	11	22	33	1	41	47	89
	G.	2	7	9	18	—	5	6	11	—	3	6	9	2	15	21	38
Organic Disorder	B.	6	7	8	21	—	4	1	5	—	1	1	2	6	12	10	28
	G.	1	2	2	5	1	2	—	3	—	—	—	—	2	4	2	8
Psychotic Behaviour	B.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	G.	—	—	1	1	—	—	1	1	—	—	—	—	—	—	2	2
Educational and Vocational Difficulties	B.	8	19	15	44	—	6	3	9	1	7	9	17	9	32	27	68
	G.	1	4	5	10	1	3	1	5	—	2	5	7	2	9	11	22
Special Investigation, e.g. adoption, etc.	B.	—	2	—	2	—	—	—	—	—	—	—	—	—	2	—	2
	G.	—	—	—	—	—	—	1	1	—	—	—	—	—	—	1	1
Unclassified	B.	—	—	—	—	—	—	—	—	—	—	1	1	—	—	1	1
	G.	—	—	—	—	—	—	1	1	—	—	—	—	—	—	1	1
*Total number of Disturbances	B.	17	64	46	127	1	26	23	50	1	27	40	68	19	117	109	245
	G.	7	19	21	47	2	14	12	28	—	6	13	19	9	39	46	94
Total		24	83	67	174	3	40	35	78	1	26	53	87	28	156	155	339
*Number of Children	B.	9	41	29	79	1	14	14	29	1	19	32	52	11	74	75	160
	G.	4	14	17	35	1	8	9	18	—	6	10	16	5	28	36	69
Total		13	55	46	114	2	22	23	47	1	25	42	68	16	102	111	229

* The number of disturbances does not necessarily agree with the number of children, as cases often present more than one type of disturbance

Dr. Orme reports as follows on the work of the Rawmarsh Centre:—

The clinic is held on Mondays in the Multiple Clinic, Barbers Avenue, which is normally used for Maternity and Child Welfare, Dental and School Clinics. Apart from a Dental Clinic, there are no other clinics in session on Monday. The Child Guidance Clinic is fully staffed with Educational Psychologist, Psychiatric Social Worker, and secretary; the Psychiatric Social Worker has at least one more day each week available for home visits in the area. Although it is greatly appreciated that there is a full team available, it is in the unusual position of being entirely male, and it will be interesting to see if this imposes any limitations in a work where all elements of personality are so important (this, of course, does not imply the slightest criticism of the individual members of the team, who are working extremely well together).

Previously, the clinic had been under the direction of the Educational Psychologist, Dr. MacTaggart, but since her resignation in 1955 no clinic had been held. On investigation of the case-notes, it was found that 115 cases had been under treatment or supervision at that time. Of these, it was apparent from the records that 56 needed no further action for one reason or another. The Divisional Medical Officers were asked to investigate the remainder, and have been most co-operative in this; from their reports a further 25 have been closed. In addition, 5 were closed after interview at the clinic or after a home visit by the Psychiatric Social Worker. 18 of the cases originally on the register are still under investigation, while 11 are in need of, and are suitable for, further treatment.

New Cases have been rapidly referred by Divisional Medical Officers, General Practitioners, and the Paediatricians. It is greatly appreciated that in most cases the doctor concerned has written about the problem in detail (a matter of great help in deciding the urgency with which the child should be seen). Up to 31st December, 1956, 26 new cases had been referred, of which 17 have been seen and 9 are on the waiting list. The clinical problems concerned vary from the psychosomatic conditions, such as asthma, through anxiety states and behaviour disturbances, to infantile psychosis. Many of the cases are needing treatment most urgently, but it is obvious that the time available is quite inadequate for the numbers concerned. Owing to the need for treatment time it is not possible to see more than one new case each week. This means that it is already taking 2–3 months to work through the waiting list, and as the list is actually growing faster than new cases are seen, the situation will soon be very much worse.

The area covered by the clinic is the whole of the West Riding area that is served by the Sheffield Regional Hospital Board, and it is this factor which gives rise to a very important difficulty—that of the distances which children have to travel. Apart from those within easy reach of the clinic, the large centres of population on the outskirts of Sheffield and around Doncaster have been the main sources of referrals— e.g. 6 cases at present under treatment are from the Parson Cross and Ecclesfield area, and these spend anything up to 1½ hours travelling each way (according to the 'bus connections), a matter of considerable importance if treatment weekly, or even fortnightly, is being contemplated. In the case of children from the country areas, it is realised that this is unavoidable, as no clinic can reasonably be expected to cope easily with problems from places as far distant as Penistone, Darton, or Stainforth. The situation is being discussed with the West Riding Authorities and it is hoped it may be possible to set up a clinic for interviews in the Ecclesfield area, though there would be no accommodation for play therapy; it may alleviate the matter a little, however, though the time would have to be taken from time already spent at Hoober House.

On the whole the clinic has had a good start and I hope it will grow to be a successful establishment, sufficient to meet the very pressing needs of the area.

The following report by Mr. Pickles gives a detailed account of the psychological tests undertaken by him during the year, together with some interesting observations on the problem of retarded readers as presented in many children referred to the child guidance centres:—

Two hundred and thirty-seven children were examined by psychological tests during the year. The great majority of these were maladjusted children referred to the five clinics operating in the County, and they were tested as part of the normal clinic procedure. Others were examined on request because they had special handicaps such as cerebral palsy, visual or auditory defects, or because they were of doubtful educability. 32 children came into this category and psychological assessments were necessary in order that appropriate recommendations could be made for training or special schooling.

Intelligence quotients are available on 213 children. A few children were untestable, while full intelligence test scales could not be applied in some cases and assessments had to be based on performance on various shorter clinical tests.

Distribution of Intelligence. The following table summarises the distribution of available intelligence quotients. These are mostly Terman Merrill I.Q.s, but a small proportion are derived from testing on the Wechsler Intelligence Scale for children and the Wechsler Bellevue Intelligence Scale.

I.Q.	below 50	50–59	60–69	70–79	80–89	90–99	100–109	110–119	120–129	130–139	above 140	Totals
Boys.. ..	12	3	3	22	20	35	27	20	11	5	2	160
Girls ..	3	1	5	4	9	10	7	8	4	–	2	53
Totals ..	15	4	8	26	29	45	34	28	15	5	4	213

None of the children with I.Q.s below 50, and only a few with I.Q.s below 70, came as normal referrals to the child guidance clinics. Nearly all of these children were known to be backward and were referred principally for psychological assessment of intellectual disabilities. But quite a large number of children in the 70–79 I.Q. range were referred for child guidance on account of various nervous or behaviour symptoms which were in need of a full psychiatric investigation. Very few of these children in the educationally sub-normal range of ability were receiving special education at the time of referral: their intellectual limitations had either not been recognised prior to diagnostic examinations at the clinics or, if they had, appropriate special educational facilities had not been available for them.

Reading Difficulties. Difficulties at school might be expected to occur as concomitant symptoms in a high proportion of children referred for child guidance. The figures for the Wakefield, Shipley and Mirfield clinics contained in Dr. Leese's report show the relative incidence of symptoms of this type. Attention is largely focused upon difficulties in learning to read, because reading is the most important basic subject in the primary school, and any reading disability can be a crippling handicap in the secondary school. Quite often parental concern is expressed about it at the first interview and the child is found to be labouring under a sense of educational failure. Remedial teaching can thus be a most useful and necessary part of the treatment of the retarded maladjusted child, helping to restore his confidence. Its implementation should be preceded by a careful diagnosis of the total problem.

Tests of reading attainment were given as a standard part of the psychological examination of most of the children seen in the clinics during the year. Comparative figures of reading attainment and intelligence level on individual tests, administered during the same examination, are available for 205 children. It was found that 65, or just over 31 per cent. of these children were retarded in reading to a degree that warranted some special help, in the school or elsewhere, taking as a criterion of retardation a discrepancy of more than 15 points between reading quotient and intelligence quotient. Most of these children, as the table below shows, were retarded to a greater degree.

Degree of Retardation %	50+	40+	30+	20+	15+
Number of children	5	12	18	21	9

They were mostly primary school pupils, 50 of them being in the age range 7–11 years; and mostly of below average or dull intelligence, only 16 having I.Q.s above 100. As research findings generally show, it is the dull child who is most likely to be significantly retarded educationally. Whatever factors may be responsible for the retardation—and they are usually multiple and complex—they tend to be accentuated by any sub-normality of intellect, since the dull child has less resilience to offset them. It is apparent that the group of dull children above the generally accepted educationally sub-normal range of intelligence contributes an unduly large problem of retardation in the ordinary schools.

So far as actual referring symptoms are concerned, it is unlikely that these retarded readers differed significantly from the general run of clinic cases. There was a preponderance of behaviour problems, there being about twice as many in this category as in any other. But this applies also to the total figures for child guidance attendance during the year. It may seem logical to argue that the child who is failing in school may try to avoid school work by truanting or may compensate for educational failure by various forms of aggressive or anti-social behaviour. Others, depending largely upon their constitutional disposition, may show various nervous symptoms. The 'couldn't-care less' attitude was fairly common, worrying parents and exasperating teachers, but this often proves to be no more than a veneer covering over a serious anxiety and a fear of further failure. Occasionally the paranoid attitude to the teacher or to the school was found, usually when it received some support, or even encouragement, from the parent.

It is extremely difficult, and it may not be possible in many cases to discover what is cause and what effect. Is the child retarded because he is maladjusted or maladjusted because he is retarded? Our data is not complete enough to give even a partial answer. But it does seem that any possible specific factors, such as crossed laterality, weakness in auditory or visual discrimination, even absences from school and various environmental deficiencies, are subordinate to the effects of emotional instability when this is present. The child's emotional attitudes, which may be severe and of long-standing, are probably the biggest obstacles to progress. There were a few children seen in whom maladjustment could possibly be considered as a secondary manifestation of scholastic failure. This was usually considered likely in the innately dull child whose dullness had not been recognised early enough, and the symptoms that arise are explicable in terms of the child's reaction to over-pressure. Such children need educational provision that will allow for their general immaturity and slower rate of mental growth. To force competitive formal learning upon them before they are ready for it, as some parents demand, with all the anxiety that this provokes, is to doom them to failure from the start.

If educational retardation is allowed to persist it can seriously jeopardise the child's progress towards better mental health. A two-fold attack is needed, upon the maladjustment itself and its origins and upon the retardation: in practice, it may matter little which is the primary problem. Accordingly, as much help as possible was given in the clinics to some of the children who were severely retarded, and remedial groups were formed and taken by the Psychologist in the clinics at Mirfield and Shipley. Twelve children were helped in the course of the year, attending for half a day each week. There were many more children who might have benefited from attendance, but facilities were not available. In fact, the therapeutic work of the clinics could be enhanced by the appointment of a full-time remedial teacher to the clinic team.

The School Ophthalmic Service

There have been no further developments in this Service during the year. The Service is under the control of the Regional Hospital Boards so far as the provision of ophthalmologists is concerned. The clinics are affiliated to the various Hospital Management Committees, who are financially responsible for the provision and repair of glasses. Glasses are provided and repaired by an optician of the parent's choice. The provision of suitable clinic premises, equipment and ancillary staff remains the responsibility of the Authority.

Children who may possibly require to be referred to the ophthalmologist are discovered by the school nurses on their frequent visits to schools or by the school medical officers at routine medical inspection. Children with defective vision are also brought to the attention of the School Health Service directly by the teachers. Particular attention is paid to visual acuity at the medical inspection at 7–8 years of age, as this is an age when defects in vision often first become apparent and, if untreated, can have a far-reaching effect on a child's education.

Particular attention is also given by the school medical officers at the medical inspection of leavers to the testing for colour vision. There are so many occupations to-day which require colour discrimination that it is important to know of the existence of a defect in colour vision before a child enters upon a chosen occupation. The Ishihara colour vision tests are now widely used by the school medical officers.

In addition to the school ophthalmic service, children can also be tested and provided with glasses through the Supplementary Ophthalmic Services administered by the Executive Councils, the children being referred to opticians on the recommendation of their own private doctor. It is not known how many children in the Authority's area receive glasses by this method.

Large numbers of children continue to attend the school ophthalmic clinics, and the following figures show the number of examinations made and the number of children prescribed glasses during 1956 compared with previous years.

Year	*No. of children examined (including re-examinations)*	*No. prescribed glasses*
1948	10,755	8,113
1949	12,345	7,830
1950	12,341	7,289
1951	12,514	6,970
1952	14,974	8,941
1953	17,659	9,462
1954	17,691	9,240
1955	17,265	9,926
1956	17,644	9,999

Medical Treatment at Clinics

As part of the Authority's arrangements under Section 48 of the Education Act, 1944, for the medical treatment of school children, the following clinics were in operation at the 31st December, 1956:—

Type of Clinic	Number	
	Provided directly by the Authority	Under arrangements with Regional Hospital Boards
Minor Ailment and other non-specialised	203	—
Dental	37	—
Ophthalmic	—	56
Speech Therapy	36	—
Orthopaedic Treatment Centres	15	—
Ultra Violet Light	47	—
Paediatric	5	12
Chiropody	3	—
Consultant E.N.T.	—	15
Consultant Orthopaedic	—	17
Consultant Dermatology	—	1
Consultant Cardiac	—	1

A detailed list of the various clinics showing the days and times open is given in Appendix 1.

Consultant E.N.T. Service

1. No. of sessions held during the year 211

	Pre-school Children	*School Children*	*Total*
2. No. of individual children seen by consultant, including those continuing attendance from previous year ..	82	1,484	1,566
3. No. of (2) above referred for operative treatment ..	93	872	965
4. No. of children—			
(a) who obtained operative treatment during the year	59	989	1,048
(b) treated at school clinics	6	90	96
5. No. of attendances at consultant clinics	151	2,112	2,263

Consultant Orthopaedic Service

A. Consultant Clinic

1. No. of sessions held during the year 197

	Pre-school Children	*School Children*	*Total*
2. No. of individual patients seen by consultant, including those continuing attendance from previous year ..	369	1,247	1,616
3. No. of (2) above—			
(a) referred for operative treatment as short-stay cases only..	9	71	80
(b) recommended long-stay hospital school	—	1	1
(c) recommended treatment by orthopaedic nurse or physiotherapist—			
(i) at treatment centres	35	218	253
(ii) domiciliary	8	10	18
4. No. of children who obtained operative treatment during the year	5	52	57
5. Total number of attendances at consultant clinic ..	558	1,832	2,390

B. Treatment Centres

1. No. of sessions held during the year	1,539	

	Pre-school Children	*School Children*	*Total*
2. Total number of patients treated (including cases continuing treatment from previous year)	110	894	1,004
3. Total number of attendances	1,323	9,751	11,074

C. Domiciliary Treatment

	Pre-school Children	*School Children*	*Total*
1. Total number treated	—	1	1
2. Total number of visits to patients' homes	303	812	1,115

D. Appliances

	Pre-school Children	*School Children*	*Total*
No. of appliances—			
(a) recommended	28	145	173
(b) obtained	22	117	139

Paediatric Service

Consultant Clinics

1. No. of sessions held during the year	189	

	Pre-school Children	*School Children*	*Total*
2. No. of individual patients seen—			
(a) New cases	107	296	403
(b) Cases attending from previous year	81	413	494
3. Total number of attendances at clinics	291	1,042	1,333

The following table gives details of the various types of defect or disease for which children were referred for consultant opinion:—

Defect or Disease	*Pre-school Children*	*School Children*	*Total*
Central Nervous System	23	26	49
Heart and Circulatory System	13	121	134
Respiratory System, including E.N.T. defects	12	105	117
Speech	5	7	12
Orthopaedic	8	6	14
Skin	—	4	4
Psychological	19	30	49
Mental Defect, including Educational Sub-normality	10	15	25
Congenital Deformities	3	6	9
Gastro-intestinal System	11	21	32
Epilepsy	11	54	65
Genito-urinary System	3	10	13
Glands	2	13	15
Nutritional	7	52	59
Developmental	24	31	55
Muscular Disease	6	3	9
Rheumatism	—	10	10
Habit Spasms	1	7	8
Incontinence	5	130	135
Migraine	1	23	24
Unclassified	24	35	59
	188	709	897

Ultra Violet Light Treatment

At the end of the year there were 47 ultra violet light clinics in operation and the following are particulars of the children treated:—

No. of sessions held	3,144	

	Pre-school Children	*School Children*	*Total*
No. of children treated during year	943	1,479	2,422
Total number of attendances	10,781	19,367	30,148

School Nursing

The school nurse, in most cases, also is a health visitor, sharing her time equally between both services. One of the most illustrative advantages of this combination of duties is the health visitor's efforts to secure the attendance of toddlers at infant welfare centres, or at special toddlers' clinics, in order to ascertain and treat defects which are otherwise to be encountered in a more progressive stage when, in her capacity as a school nurse, she sees the child at the first school medical inspection.

With the increasing demands on the school nurse's time, in both fields of her work, it is essential that her manifold duties should be under constant review to ensure that she is being used to the best advantage. It is with this aspect in mind that one questions the need for hygiene inspections of each school child three times a year; the standard of hygiene in school children continues to improve with the exception of the same few who create the problem time after time, and it might be preferable to limit the inspections to these known defaulters and to those specially referred by the teacher. Similarly with minor ailment sessions, where attendances continue to fall and when the incidence of scabies and impetigo is so less marked. A third field of enquiry is in the routine school medical inspections, involving, during the past year, 89,564 children, each of whom had to be weighed and measured by the school nurse.

School nurses spent 888 sessions teaching parentcraft to school children. They attended specialist clinics (2,595 sessions), minor ailment clinics (9,210 sessions) and special defect clinics (1,149 sessions); ultra-violet light clinics accounted for a further 3,164 sessions, although the numbers of such clinics and the attendances are falling. School medical inspections represented 7,218 sessions, cleanliness surveys 5,155 sessions and special visits to schools a further 7,586 sessions. The school nurse also visits the homes to follow-up children found with medical defects at routine medical inspections, handicapped pupils, and cases of infectious disease. During the year 27,391 visits were made.

Vaccination and Immunisation

Particulars relating to the numbers of school children immunised against diphtheria during the year and the immunisation state of the population of children of school age will be found in the section of the Report dealing with Epidemiology.

During the year vaccination against poliomyelitis was introduced for children in the 2 to 9 age group and particulars of the scheme will be found in the same section of the Report.

The schemes for vaccination and immunisation could not work nearly so smoothly without the co-operation which is given so readily by headteachers and their staffs.

Cleanliness

The following figures show the number of children found to be suffering from head infestation during the year compared with previous years:—

Year	Total number of examinations made by school nurses	No. of individual children found to be infested	% of school population
1947	368,370	24,862	11·3
1948	560,631	27,361	12·4
1949	574,968	23,457	10·5
1950	523,473	20,214	8·8
1951	559,388	18,599	7·9
1952	610,201	19,772	8·1
1953	575,645	17,815	7·1
1954	549,961	13,619	5·3
1955	547,369	11,657	4·5
1956	512,868	10,379	3·9

The figures for 1956 show a further gradual decrease in the incidence of infestation—a tribute to the increasing attention which is given to this condition by the school nurses. The figure of 10,379 infested children is still far too high when one considers how easily and quickly the condition can be remedied successfully to-day with the choice of preparations available. There is little hope that head infestation will ever be eradicated entirely in school children so long as there remains a hard core of shiftless and neglectful parents who continually allow their children to become re-infested in their own homes.

Nutrition

Yet another change was made by the Ministry in 1956 in the classification of school children at medical inspection. Prior to 1947 children were classified A (Excellent), B (Normal), C (Slightly Sub-normal), or D (Bad). The basis for grouping was largely determined by the nutritional state of the child. In 1947 the classification was changed to A (Good), B (Fair or Normal), and C (Poor) and was no longer a nutritional classification but one of general physical condition. From 1956 onwards the classification becomes a straight choice between 'satisfactory' and 'unsatisfactory'. While this further change is to be welcomed in that the classification is easier to determine and resultant figures are not so likely to reflect differing standards employed by different school medical officers, at the same time it is to be regretted that comparisons with previous years will not be possible. For instance, the following table is interesting in that it shows a gradual improvement between 1947 and 1955 in the numbers of children in the good (or above normal) category at the expense of the fair (or normal) and poor categories.

Year	Total number of pupils inspected	Classification					
		A (Good)		B (Fair)		C (Poor)	
		No.	% of Col. 2	No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1947	50,277	19,497	38·8	28,343	56·4	2,437	4·8
1948	71,858	26,077	36·3	41,876	58·3	3,905	5·4
1949	64,998	23,467	36·1	39,335	60·5	2,196	3·4
1950	61,977	26,820	43·3	33,528	54·1	1,629	2·6
1951	64,676	29,452	45·5	33,598	51·9	1,626	2·5
1952	62,156	30,506	49·1	30,635	49·3	1,015	1·6
1953	77,803	35,861	46·1	40,772	52·4	1,170	1·5
1954	79,553	40,315	50·7	38,344	48·2	894	1·1
1955	87,520	47,959	54·8	38,872	44·4	689	0·8

One would assume that the new classification would result in A (Good) and B (Normal) being classed together as Satisfactory and C (Poor) as Unsatisfactory, thus in 1955 99·2 per cent. of children examined would have been satisfactory and 0·8 per cent. unsatisfactory. The actual figures for 1956, however, under the new classification give 97·5 per cent. as satisfactory and 2·5 per cent. as unsatisfactory. Any figures of comparison of the 1956 findings with previous years will have to be used with some degree of caution.

School Meals.—The number of meals provided to school children daily according to a check made in October 1956 was 125,053, compared with 127,530 in October 1955. This represents 50·41 per cent. of children on the registers.

Medical Examination of Entrants to Training Colleges

In connection with their applications for entry to Training Colleges, 1,028 students were medically examined during the year by the school medical officers, compared with 952 for the year 1955 and 886 for the year 1954.

Children and Young Persons Act, 1933
Employment of Children

Under the Authority's bye-laws relating to the employment of children, 1,557 children were examined during the year by the school medical officers to determine their fitness for employment. The figure includes children taking part in entertainments. Seven cases only were found unfit.

Youth Employment Service

There is close liaison between the officers in the School Health Service and those in the Youth Employment Service. The Youth Employment Officers visit schools to discuss with teachers and parents the type and suitability of occupations of those children about to leave school.

Prior to this the leavers will have received their final routine medical inspection and the schoo medical officer will have informed the Youth Employment Officer of those children who are handicapped in such a way that their choice of occupation is limited.

After the handicapped child enters employment the services of the school medical officer are still available to advise the Youth Employment Officer if any difficulty is encountered either regarding the actual occupation or from the point of view of the employer.

Protection of School Children Against Tuberculosis

Tuberculin Testing of Entrants.—The purpose of giving a tuberculin test to young children on entry to school is that positive test results lead to—

(a) the search for a responsible source of infection, thus affording a valuable method of tuberculosis case-finding, and

(b) the placing of the young child under medical supervision until the risks following primary infection are eliminated.

Routine testing was undertaken in eight Divisions during the year. A total of 3,382 children were tested, of whom 113 gave a positive result. These children were followed-up through the Chest Physicians and X-rayed where considered necessary. Investigations were also made into the home contacts of these children.

B.C.G. Vaccination of Older School Children.—Particulars of the Authority's scheme for the B.C.G. vaccination of thirteen-year-old children and of the number of children dealt with during 1956 will be found in that part of the County Medical Officer's Report dealing with Section 28 of the National Health Service Act, 1946—Care and After Care, Prevention of Illness, etc.

The Work of a Children's Specialist in the School Health Service

The following notes relating to school children are taken from a report on the year's work submitted by Dr. Harvey, Paediatrician:—

Emotional Maladjustment

The old distinction between heredity and environment has changed and a new meaning is being recognised. Environment itself is now shown to be inherited, for instance, Bowlby's demonstration of the self-perpetuating hazards of unstable parents breeding children whose capacity for living has atrophied, so that they grow up without the ability to make secure homes in turn for their own children.

In our clinical work we see too many children whose care has been devolved by parents upon the grandparents, who are often ill-qualified by age or health or dogmatism to give the children an ideal upbringing. It happens particularly when mother goes out to work, both parents, perhaps, plunging into industry on different shifts, leaving their child to the grandmother, with ostrich-eyed indifference to the youngster's emotional unfolding. It happens with overcrowded households, in which a number of aunts may confuse the child's developing relationships. Too many grandmothers retain the first-born child after the young parents secure their own house, and the parents dare not risk a domestic rumpus by claiming their offspring back from the possessive old lady. I am still seeing children from families which have been scattered across the County in different Institutions because the parents either are poor copers or are said to have no room to keep their children together.

Now that we are beginning to work actively with Child Psychiatrist colleagues, we are exercised about the demarcating of our provinces. With the occasional child who funks school badly is it for us to treat on domestic paediatric lines or should it be a psychiatric problem for the Child Guidance Clinic? There was the 10-year-old girl who had stayed away from school 18 months with butterflies in her stomach. Did the paediatrician and the school doctor do her harm by telling her to pick up her musket and return to school, which she did—or did we leave some fundamental psychiatric problem unsolved?

Doubt about Quarantine for Children

Now that antibiotic control of complications has improved, is it not, in fact, causing inconvenience at a later and more important age of life, if we stave off the contracting of rubella, measles, chicken pox and "scarlet fever" until adolescence or adult life? Would we do better to abolish quarantine except for the protection of children in special examination test classes? The two chief risks are that girls may grow up without having had rubella, which they might very well have got over in childhood, and, secondly, that children who have escaped infectious diseases may be stricken down just before important interviews or examinations.

Doubt about so-called Scarlet Fever

Is our profession doing more harm than good by preserving a name which by its very use draws attention away from streptococcal sore throats without rash, which are equally a cause of rheumatic and nephritic illnesses? Is there any value in isolation of the child with a rash while nothing is done about children with sore throats in the absence of a rash? Does isolation deflect our attention from the advantages of penicillin or sulphonamide prophylaxis for all contacts, together with bacterial sampling rather than hospital or home isolation?

Doubt about Tonsillectomy

("*Is your tonsillectomy really necessary*?")

Some of us are as irrationally intolerant of tonsils as the Army is of soldiers' beards. The disconcerting reversed social gradient of tonsillectomy still remains unexplained, as if well-to-do children were born with a golden guillotine in their mouth. It is all too easy to advise tonsil operations on the basis of "try anything once", for children with periodic recurrent symptoms, such as respiratory allergy or unrecognised migraine. This heart-searching has now reached the pages of "Family Doctor".

Doubt about migraine

Discussion in the journals during the year has shown increasing recognition of how widespread migraine is in childhood, particularly its abdominal manifestations, which lead to a number of unwary appendicectomies. To call migraine a stress disorder is to miss the true perspective and is unfair to the subjects of this particular sort of physiological vasomotor mechanism. To call a thing psychosomatic is by no means an adequate diagnostic label. Migraine is a somatic mechanism which is susceptible to aggravation or precipitation by a wide variety of causes, including psychic stress, but it is no more intrinsically psychological than is menstrual herpes. Stress enters into it when the migrainous child gets spectacles prescribed unfairly, or has his tonsils whipped, or undergoes appendicectomy during a bout of his vomiting, headache and abdominal pain.

THE SCHOOL DENTAL SERVICE

The following is the Report of the Principal School Dental Officer and Orthodontic Consultant, Mr. B. R. Townend, F.D.S., R.C.S. (ENG.), L.D.S. (LIV.), DIP. ORTH. R.C.S.:—

I must, unfortunately, once more preface my report with a reference to the sorry state of our staffing problems. In 1944 the County Council agreed to an establishment of 69 dental officers. At the present moment we have 24 vacancies on that establishment. But that is not all. Since 1944 the school population has materially increased from 208,000 in that year to 261,000 in 1956. In the current Report of the Chief Medical Officer to the Ministry of Education, "The Health of the School Child", it is stated that "the Minister in recent years has indicated that a ratio of at least one dentist to 3,000 children would be required for a complete service", and it is emphasised that this is a statement of minimum staffing needs. On this assumption it will be seen that the establishment of dental officers to deal with the school population should be 87, and in addition to this there are the ever-increasing demands of the Maternity and Child Welfare Services. No attempt has been made to suggest that the County Council should create an official establishment other than the one set up in 1944, as we cannot hope to hit that target within the foreseeable future, but we cannot regard our position with any complacency when we realise that in order to tackle our task efficiently we should need an establishment in the region of 100 dental officers. There are one or two faint gleams of light which may enlighten the darkness of the future. There has been a growing consciousness in the country of the grave state of services for dentistry, and this concern has culminated during the year in the setting up of a government committee to study the problem of the supply of dentists. This committee has published its report and made certain recommendations which, if implemented, should materially improve the situation in the future.

The coming into law of the Dentists Act, 1956, has legalised the carrying out of an experiment in the establishment of a new class of ancillary workers similar to those employed in New Zealand. The employment of these workers has been the subject of some controversy, but with certain safeguards, I would consider that they would fill a valuable role in school dentistry. The time seems to have come when traditional procedures should be somewhat altered and adapted. The time and effort of men trained at great expense to society should not be wasted on anything which can be safely delegated, under supervision, to those of lesser training.

For the first time in the history of the School Dental Service the Ministry have asked for a special return of orthodontic work carried out by Local Education Authorities. This is an indication of the increasing interest which is being taken of this branch of dental surgery, and you are aware that we in the West Riding have always been aware of and have, in fact, anticipated the importance of orthodontics. The figures given in the table indicate the large volume of work which is being done. Of particular interest and, I think, a cause for congratulation, is the low figure of 83 cases which have been discontinued during the year, because this figure includes not only those who have fallen by the wayside and have failed to stay the course, but a quite considerable number of children who have left the district and have been transferred to other Authorities. It is very encouraging to those of us who are practising orthodontics that in spite of the fact that many of our patients have to make long journeys to our clinics, the appreciation of the service they receive is very high.

More and more private practitioners who have not the facilities, the time, or the inclination to carry out orthodontic treatment are referring cases to us, and we are developing a flourishing consultant service.

Dental Inspection and Treatment Carried Out During the Year

1.	Inspections—	
	(a) Routine	101,682
	(b) Specials	8,927
	Total (1)	110,609
2.	Number found to require treatment	79,285
3.	Numbered offered treatment	68,395
4.	Number actually treated	52,837
5.	Number of attendances	115,016
6.	Half-days devoted to—	
	Inspection	968
	Treatment	17,304
	Total (6)	18,272
7.	Fillings—	
	Permanent Teeth	63,418
	Temporary Teeth	3,310
	Total (7)	66,728
8.	Number of teeth filled—	
	Permanent Teeth	57,255
	Temporary Teeth	3,186
	Total (8)	60,441
9.	Extractions—	
	Permanent Teeth	17,783
	Temporary Teeth	75,802
	Total (9)	93,585
10.	Administration of general anaesthetics for extractions	22,517
11.	Orthodontics—	
	(a) Cases commenced during the year	1,230
	(b) Cases brought forward from previous year	2,368
	(c) Cases completed during the year	642
	(d) Cases discontinued during the year	83
	(e) Pupils treated with appliances	1,027
	(f) Removable appliances fitted	1,216
	(g) Fixed appliances fitted	283
	(h) Total attendances	14,363
12.	Number of pupils supplied with artificial dentures	549
13.	Other Operations—	
	Permanent Teeth	32,340
	Temporary Teeth	3,581
	Total (13)	35,921

In addition to the above the following work has been carried out by Dental Hygienists:—

Children treated	608
No. of attendances	825

Analysis of Work carried out during the Year.—The information concerning dental treatment provided for school children in the above table gives a very limited picture of the actual work done, and the following implementations and refinements to the table may be of interest.

The total of 75,802 temporary teeth and 17,783 permanent teeth extracted does not represent, as might be thought, so many teeth which it has been found impossible to save. No less than 11,462 temporary teeth and 2,185 permanent teeth have been extracted with a view to making room for the other teeth or to ensure in various ways that succeeding teeth shall grow in regular order. Approximately 1 tooth in 7 is extracted with the object of preventing irregularity and ensuring the satisfactory future of the dentition.

3,310 temporary teeth were conserved by the following means: 1,339 cement fillings, 526 amalgam fillings, 1,465 combined cement and amalgam fillings. 34,623 first permanent molars and 22,632 other teeth, a total of 57,255 permanent teeth, were conserved by the following means: 1,071 cement fillings, 8,989 amalgam fillings, 47,328 combined cement and amalgam fillings, 6,030 silicate (porcelain) fillings. Other treatments of a varied nature include 146 root fillings, 5,304 dressings, 177 crowns, inlays, etc., 4,941 scalings and gum treatments. Dentures were provided in 549 cases to replace teeth lost by accident or disease, 1,693 attendances being made for the necessary work incurred in the fitting of these dentures.

The very large figure of 35,921 other operations which appears in the table merits some explanation. It represents an omnibus classification of all cases which receive dental attention of various kinds other than those falling into the categories specifically mentioned.

It includes such things as 14,363 attendances for orthodontic treatment, 1,693 attendances for prosthetic treatment, 4,941 scalings and gum treatments, 1,486 X-rays, 5,304 dressings, etc.

KEIGHLEY EXCEPTED DISTRICT

The following report on the year's work is submitted by Dr. H. M. Holt, the School Medical Officer to the Keighley Excepted District:—

I have the honour to submit this, my twenty-seventh, Annual Report on the work of the Health Services of the Borough for the year 1956.

The re-opening of Humphrey Head Camp on 6th June marked a highlight in the School Health Service of the Borough—the advantages gained by the children who visit this Camp cannot be expressed statistically, but to those of us who come into close contact with them, these are obvious enough. That it was closed was a source of great disappointment to me, but, as it turns out, it has proved a blessing, the improved facilities are on lines so generous that they would never have been realised had the Camp continued the even tenor of its way over the years.

The Committee approved estimates for the repair and redecoration of the School Clinic to the amount of £640, and the work was put in hand. The School Clinic is one of the greatest assets to the School Medical Service, and I am proud of the facilities it offers and the conditions under which they are provided.

In view of the limited use being made of the Haworth Minor Ailments Clinic the practice of holding weekly clinics thereat was discontinued as from 25th February. The children who attended were referred to the Haworth Child Welfare Centre, held in the Hall Green Baptist Chapel weekly on Tuesday afternoons. The change has not affected the children and has been a more economical way of meeting the position.

There is very little to report on so far as the routine work of the Service is concerned. Infectious disease has not assumed any more than normal proportion and we have had no staff difficulties.

I have, as usual, enjoyed all the help and co-operation I could desire from colleagues in other branches of the Service and all the loyalty and support from my staff.

I appreciate all the assistance I have received from the Headquarters Staff at Wakefield and the help and encouragement from those it is my duty to serve.

I am,

Your obedient servant,

H. M. HOLT,

School Medical Officer.

Medical Inspection of School Children

This service provides for the routine medical inspection of all scholars on four separate occasions during their school life with special examinations and re-examinations as necessary, the arrangement being that—

(a) every pupil who is admitted for the first time to a maintained school shall be inspected as soon as possible after the date of admission;

(b) every pupil attending a maintained primary school shall be inspected during the year in which the age of 8 years is attained;

(c) every pupil attending a maintained secondary school shall be inspected as soon as possible after admission to such a school;

(d) every pupil attending a maintained secondary school shall be inspected during the last year of attendance at such a school.

Special arrangements have been made to secure a more frequent examination of those pupils in attendance at Nursery Schools, Braithwaite Open Air School, Whinburn Special School and Branshaw View Occupation Centre.

Having regard to the Authority's Youth Employment Service particular attention has been given to the medical examination at paragraph (d) above. The Area Youth Employment Officer is visiting schools and interviewing parents during or near the child's last term at school. In order that he may know whether there is any physical or mental defect which might, in the opinion of the School Medical Officer, restrict a choice of employment, pupils receive their final periodic medical inspection at the commencement of or immediately prior to entering upon their last term at school. The greatest care is taken to ensure that all information passed to the Area Youth Employment Officer is treated as confidential.

The average number of pupils on the registers at the end of the year was as follows:—

Nursery	40
Primary	5,735
Secondary Modern	1,557
Secondary Grammar ..	1,275
Secondary Technical ..	303

The following table gives details of the number of medical inspections corresponding to the various age groups as set out above.

TABLE I

Medical Inspection of Pupils attending Maintained Primary and Secondary Schools (including Special Schools).

A. PERIODIC MEDICAL INSPECTIONS

Number of Inspections in the prescribed groups:—

Entrants	722
7 to 8 year group	810
First year secondary	942
Last year secondary	503
Additional periodic	—
Total	2,977

B. OTHER INSPECTIONS

Number of Special Inspections ..	2,380
Number of Re-inspections ..	1,417
Total	3,797

C. PUPILS FOUND TO REQUIRE TREATMENT

Number of individual pupils found at periodic medical inspection to require treatment (excluding Dental Diseases and Infestation with Vermin).

Age Groups Inspected (1)	For Defective Vision (excluding squint) (2)	For any of the other conditions recorded in D. (a) below (3)	Total Individual Pupils (4)
Entrants	1	108	109
7 to 8 year group	25	108	129
First year secondary	64	245	292
Last year secondary	29	118	144
Additional periodic	—	—	—
Total	119	579	674

D. Defects found by Medical Inspection in the Year ended 31st December, 1956

All defects noted at medical inspection as requiring treatment are included in the following tables, whether or not treatment was begun before the date of the inspection.

(*a*) *Periodic Inspections*

Defect Code No. (1)	Defect or Disease (2)	Periodic Inspections				TOTAL (including all other age groups inspected)	
		Entrants		Leavers			
		Requiring treatment (3)	Requiring observation (4)	Requiring treatment (5)	Requiring observation (6)	Requiring treatment (7)	Requiring observation (8)
4	Skin	9	10	27	4	58	34
5	Eyes—a. Vision	1	5	29	70	119	203
	b. Squint	10	15	1	1	22	49
	c. Other	3	2	—	2	11	8
6	Ears—a. Hearing	4	9	1	1	9	21
	b. Otitis Media	3	8	—	1	5	16
	c. Other	2	—	—	—	2	2
7	Nose and Throat	38	62	7	4	84	132
8	Speech	10	11	—	—	21	15
9	Lymphatic Glands	—	20	—	3	2	35
10	Heart	—	13	—	4	2	37
11	Lungs	6	24	1	2	20	52
12	Developmental—a. Hernia	1	2	—	—	3	2
	b. Other	1	57	—	—	6	76
13	Orthopaedic—a. Posture	7	2	52	2	220	23
	b. Feet	16	22	21	3	105	35
	c. Other	4	17	5	2	19	32
14	Nervous System—a. Epilepsy	—	—	—	—	—	3
	b. Other	—	5	—	—	1	7
15	Psychological—a. Development	1	3	—	—	4	11
	b. Stability	1	9	—	54	2	208
16	Abdomen	—	5	1	—	3	9
17	Other	6	10	11	14	53	52

(*b*) *Special Inspections*

Defect Code No. (1)	Defect or Disease (2)	Special Inspections	
		Requiring Treatment (3)	Requiring Observation (4)
4	Skin	201	24
5	Eyes—a. Vision	79	190
	b. Squint	23	20
	c. Other	47	8
6	Ears—a. Hearing	15	20
	b. Otitis Media	10	3
	c. Other	2	2
7	Nose and Throat	50	71
8	Speech	62	23
9	Lymphatic Glands	2	7
10	Heart	14	41
11	Lungs	48	31
12	Developmental—a. Hernia	1	3
	b. Other	—	14
13	Orthopaedic—a. Posture	26	7
	b. Feet	43	25
	c. Other	55	18
14	Nervous System—a. Epilepsy	4	7
	b. Other	7	4
15	Psychological—a. Development	73	31
	b. Stability	3	6
16	Abdomen	—	1
17	Other	726	31

E. Classification of the General Condition of Pupils Inspected during the Year

Age Groups Inspected (1)	Number of Pupils Inspected (2)	Satisfactory		Unsatisfactory	
		No. (3)	% of Col. 2 (4)	No. (5)	% of Col. 2 (6)
Entrants	722	692	95·85	30	4·15
7 to 8 year group	810	786	97·04	24	2·96
First year secondary	942	939	99·68	3	0·32
Last year secondary	503	503	100·00	—	—
Additional periodic	—	—	—	—	—
Total	2,977	2,920	98·09	57	1·91

All cases of poor nutrition are investigated and severe cases are referred for admission to the Open Air School. The provision of free milk and mid-day meals at school has done much to improve the general condition of school children. In addition, arrangements have been made for the issue of branded foods free of charge to appropriate cases, the distribution of such foods is made on the authorisation of the School Medical Officer, who examines each case prior to an issue being approved. The following foods were distributed under the provisions of this scheme during the year:—

Adexolin	224	Maltoline	27
Fersolate	124	Minadex	72
Halibut Liver Oil Capsules	924	Vitamin C	126

Infestation with Vermin

The scheme for ensuring cleanliness at schools within the Borough provides, as far as possible, for the inspection of children and their clothing once during each school term throughout the year. Details of the work carried out are given in the following table:—

Table II

(i)	Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	16,726
(ii)	Total number of *individual* pupils found to be infested	566
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	—
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944)	—

Treatment

In groups 1, 2 and 3 treatment provided by the Authority includes all defects treated or under treatment during the year by the Authority's own staff however brought to the Authority's notice, i.e. whether by periodic inspection, special inspection or otherwise, during the year in question or previously. Treatment provided otherwise than by the Authority includes all treatment known by the Authority to have been so provided, including treatment undertaken in School Clinics by the Regional Hospital Board.

Group 1. Eye Diseases, Defective Vision and Squint

	Number of cases dealt with	
	By the Authority	*Otherwise*
External and other, excluding errors of refraction and squint ..	70	—
Errors of refraction (including squint)	—	243
Total	70	243
Number of pupils for whom spectacles were prescribed	—	185

During the year 199 cases of defective vision and 44 cases of squint were examined by the Visiting Ophthalmic Surgeon, a further 70 cases suffering from other conditions of the eye such as Blepharitis and Conjunctivitis were treated at the Minor Ailments Clinic.

After testing there were 28 cases in which spectacles were not prescribed, 12 cases where existing spectacles were found to be satisfactory and 18 cases referred to the Bradford Eye and Ear Hospital.

The number of repairs to and replacement of spectacles amounted to 220.

Group 2. Diseases and Defects of Ear, Nose and Throat

	Number of cases dealt with	
	By the Authority	*Otherwise*
Received operative treatment—		
(a) For diseases of the ear	—	—
(b) For adenoids and chronic tonsillitis	—	—
(c) For other nose and throat conditions	—	—
Received other forms of treatment	31	—
Total	31	—
Total number of pupils in schools who are known to have been provided with hearing aids—		
(a) in 1956	—	—
(b) in previous years..	—	2

The following figures show the number of children found at medical inspection to have undergone tonsillectomy during 1956 or previously.

TABLE III

Age groups inspected	Number inspected	Number found to have undergone tonsillectomy during 1956 or previously
Entrants	722	46
7 to 8 year group	810	141
Last year primary	—	—
First year secondary	942	276
Last year secondary	503	153
Total	2,977	616

GROUP 3. ORTHOPAEDIC AND POSTURAL DEFECTS

	Number of cases treated	
	By the Authority	*Otherwise*
Number of pupils known to have been treated at clinics or out-patient departments	238	—

Consultant Clinic

1. No. of sessions held during year	8	
	Pre-school Children	*School Children*
2. No. of individual patients seen by consultant, including those continuing attendance from previous year	3	65
3. No. of (2) above—		
(a) referred for operative treatment as short-stay cases only	—	—
(b) recommended long-stay hospital schools	—	—
(c) recommended treatment by orthopaedic nurse or physiotherapist		
(i) at treatment centres	1	11
(ii) domiciliary	—	—
4. No. of children who obtained operative treatment during the year	—	2
5. Total number of attendances at consultant clinic	3	91

Treatment Centres

1. No. of sessions held during year	507	
	Pre-school Children	*School Children*
2. Total number of patients treated (including cases continuing treatment from previous year)	6	238
3. Total number of attendances	6	3,183

Domiciliary Treatment

1. Total number treated	—	—
2. Total number of visits to patients' homes	—	—

Appliances

Number of appliances recommended	—	6

The following shows details of the work undertaken by the Authority's Physiotherapist during the year.

TABLE IV

School Children	*No. of Cases*	*Attendances*
Asthma	16	201
Bronchitis	13	203
Breathing	35	458
Poor chest development	7	135
Postural drainage	4	193
Flat feet	65	635
Round shoulders	8	55
Knock knees	1	2
Hallux rigidus	2	7
Claw foot	4	106
Posture	28	358
Kyphosis	7	115
Scoliosis	13	166
Central nervous system	1	26
Anterior poliomyelitis	5	84
Torticollis	2	54
Rheumatism	2	51
Hemiplegia	1	31
Graduated exercises	1	7
Spastics	4	114
Stoop	12	59
Friedrich's ataxia	1	—
Cerebral palsy	1	31
Lordosis back	1	3
Erbs palsy	1	6
Congenital heart	3	83
Total	238	3,183
Pre-School Children		
Flat feet	5	5
Knock knees	1	1
Total	6	6

Attendances at the Orthopaedic Swimming Class 328

GROUP 4. DISEASES OF THE SKIN (excluding uncleanliness)

Number of cases treated or under treatment during the year by the Authority:—

Ringworm—(1) Scalp	4
(2) Body	18
Scabies	9
Impetigo	55
Other skin diseases	1
Total	87

As in previous years, a large part of the work carried out at the minor ailments clinic consisted of the treatment of cuts, abrasions, septic fingers and skin diseases. The number of cases of scabies among school children again proved abnormal compared with the figures for the previous four years.

1952	1 school child treated
1953	Nil
1954	Nil
1955	8 school children treated
1956	9 school children treated

GROUP 5. CHILD GUIDANCE TREATMENT

Number of pupils treated at Child Guidance Clinics under arrangements made by the Authority 10

The County Council's Child Guidance Team, consisting of a Psychiatrist, a Child Guidance Psychologist and a Psychiatric Social Worker, holds sessions at Shipley to which children from this area are referred.

Group 6. Speech Therapy

Table V

Number of pupils treated by Speech Therapist under arrangements made by the Authority .. 73

Details of the work carried out by the Authority's Speech Therapist during the year are set out below:—

1.	No. of half-day sessions held during year	227
2.	No. of new cases treated during year	32
	No. of cases attending for treatment from previous year	41
	Total number of cases treated	73
3.	No. of cases awaiting treatment at end of year	36
4.	No. of visits made to schools	—
5.	No. of home visits	1

Analysis of cases treated

	Number	
	Boys	*Girls*
Stammering	15	6
Defects of—		
Articulation—		
(a) Dyslalia	27	5
(b) Sigmatism	4	5
(c) Rhinolalia, due to—		
(i) Cleft Palate	6	–
(ii) Nasal obstruction	–	–
(d) Dysarthria	2	–
Aphasia	–	–
Defective speech due to—		
(i) Educational sub-normality	2	–
(ii) Deafness	–	–
Retarded speech development	1	–
Dysphonia	–	–
Other defects	–	–

Analysis of cases discharged

	Number	
	Boys	*Girls*
No. of children discharged during year	24	9
Speech normal	13	4
Speech improved	7	2
Unsuitable for treatment	1	–
Non-co-operation	1	1
Left School	–	1
Left district	–	–
Other reasons—		
Refused treatment	1	1
Parent unable to attend	1	–

Group 7. Other Treatment Given

(a)	Number of cases of miscellaneous minor ailments treated by the Authority	881
(b)	Pupils who received convalescent treatment under School Health Service arrangements	3
(c)	Pupils who received B.C.G. vaccination	164
(d)	Ultra Violet Light	36

In addition to the 881 children who received treatment at the Clinic for miscellaneous minor ailments a further 30 cases were kept under observation, all cases being initially examined by the School Medical Officers.

Of the 36 school children who received ultra violet light treatment at the School Clinic 10 were still under treatment at the end of the year. Through the interavailability of clinics 31 pre-school children also received ultra violet light treatment, of these 2 were cured, 18 improved and 11 were still under treatment at the end of the year. Altogether 79 sessions were held at the clinics and 968 attendances were made.

Dental Inspection and Treatment

The arrangement as regards the dental inspection of pupils is that:—

(a) Every pupil who is admitted for the first time to a maintained school shall be inspected by a dental officer as soon as possible after the date of admission, and

(b) Every pupil attending a maintained school or County College shall be inspected by a dental officer on such later occasions as may be practicable and necessary.

Details of the inspections and treatment carried out during the year in connection with this service are given in the following table:—

TABLE VI

1.	Number of pupils inspected—	
	(a) At periodic inspections	4,951
	(b) At Specials	606
	Total (1)	5,557
2.	Number found to require treatment	3,153
3.	Number offered treatment	3,153
4.	Number actually treated	2,913
5.	Number of attendances	6,098
6.	Half-days devoted to—	
	Periodic (School) Inspection	40
	Treatment	860
	Total (6)	900
7.	Fillings—	
	Permanent teeth	4,229
	Temporary teeth	130
	Total (7)	4,359
8.	Number of teeth filled—	
	Permanent teeth	4,065
	Temporary teeth	129
	Total (8)	4,194
9.	Extractions—	
	Permanent teeth	1,200
	Temporary teeth	3,789
	Total (9)	4,989
10.	Administration of general anaesthetics for extraction	891
11.	Orthodontics—	
	(a) Cases commenced during the year	32
	(b) Cases carried forward from previous year	57
	(c) Cases completed during the year	27
	(d) Cases discontinued during the year	9
	(e) Pupils treated with appliances	36
	(f) Removable appliances fitted	60
	(g) Fixed appliances fitted	3
	(h) Total attendances	627
12.	Number of pupils supplied with artificial dentures	22
13.	Other Operations—	
	Permanent teeth	2,229
	Temporary teeth	77
	Total (13)	2,306

Handicapped Pupils

Details of the number of handicapped pupils are given in the following table:—

TABLE VII

Category	At a Special School	At an Ordinary School	Receiving Home Tuition	At no School	Not receiving suitable education
Blind	1	—	—	1	1
Partially Sighted	5	—	—	—	—
Deaf	7	2	—	—	—
Partially Deaf	2	—	—	—	—
Educationally Sub-normal	4	18	1	—	18
Epileptic	1	2	—	—	—
Maladjusted	4	3	—	—	3
Physically Handicapped	5	6	—	—	—
Speech Defect	—	—	—	—	—
Delicate	81	15	4	—	15
Total	110	46	5	1	37

The Open Air School for Delicate Children

The Open Air School at Braithwaite has accommodation for 50 boys and 50 girls.

The children who attend this school are selected for admission from the secondary modern and primary schools by the School Medical Officers at the routine inspections and at the school clinic. Many children are referred, too, by their family doctors, by their teachers and by their parents, who find that the children are not progressing well at ordinary schools.

After admission, each child is examined by a School Medical Officer at least once each year and the parents are invited to be present at these examinations to discuss their child's health and progress.

The relevant figures for 1956 are given below:—

No. of children on register at 1st January, 1956	89
No. of admissions	26
No. of re-admissions	12
No. of children discharged—	
(a) As fit to attend ordinary school	36
(b) Transferred to Secondary Technical School	—
(c) Transferred to Special Schools	1
(d) Transferred to Hospital Schools	4
(e) On reaching school leaving age	1
No. of children on register at 31st December, 1956	85

Mentally Defective Children

Five children were notified as being ineducable during the year ended 31st December, 1956, under the provisions of Section 57 (3) of the Education Act, 1944.

Co-ordination

The scheme for co-ordination between the Maternity and Child Welfare and School Health Services continues on much the same lines as hitherto, that is to say school clinic facilities are at the disposal of mothers and children under five years of age, by arrangement with the School Medical Officers and the School Dental Surgeons. Specialist Services are available where required, cases being referred to the appropriate consultant at the Keighley Victoria Hospital. The West Riding County Council provide for the training and treatment of handicapped pupils and the Regional Hospital Board for the treatment of cases of tuberculosis by arranging admission to sanatoria or attendance at the local Chest Clinic.

School Hygiene

The School Medical Officers are required as part of their duties to make a superficial inspection of school buildings, any improvements thought necessary or deficiencies noted are the subject of a recommendation to the local Education Authority.

Follow-up of Medical Inspections

The following is a summary of the domiciliary visits made by Health Visitor/School Nurses throughout the year:—

Infectious Diseases	116
Handicapped Pupils	13
Neglected and Verminous	61
Routine Medical Inspections—Follow-up	88
Other visits	181
Total	459

Medical Examination of Entrants to Training Colleges

Twenty-two students were medically examined during the year in connection with their applications for entry to Training Colleges.

Infectious Diseases

Details are given below of the final numbers according to sex and age, after corrections subsequently made either by the notifying medical practitioner or by the medical superintendent of the infectious diseases hospital, of all cases of infectious and other notifiable diseases which occurred in children resident within the Borough up to and including the age of 14 years throughout the year.

TABLE VIII

	Scarlet Fever		Whooping Cough		Measles (excluding Rubella)		Dysentery	
	M.	F.	M.	F.	M.	F.	M.	F.
Final numbers after correction—								
Under 1 year	–	–	16	21	1	1	–	1
1 year	–	1	10	13	1	–	3	1
2 years	2	1	13	24	3	1	3	2
3 years	1	2	15	17	1	2	3	5
4 years	1	3	17	16	2	2	6	1
5–9 years	5	7	34	39	2	4	10	4
10–14 years	3	3	2	6	1	1	7	3

	Acute Pneumonia		Tuberculosis					
			Respiratory		Meninges and C.N.S.		Other	
	M.	F.	M.	F.	M.	F.	M.	F.
Final numbers after correction—								
Under 5 years	1	3	–	1	–	1	1	–
5–14 years..	2	1	1	–	–	–	2	1

Immunisation against Diphtheria and Whooping Cough

(a) *Diphtheria.*—Facilities are offered free of charge to the parent or guardian of every child for immunisation against diphtheria either by the Authority's staff or by a registered medical practitioner. Details of the number of children immunised against diphtheria are given in the following table:—

TABLE IX

	AGE at date of final injection (as regards A) or of reinforcing injections (as regards B)			
	Under 1	1 to 4	5 to 14	Total
A. Number of children who completed a full course of primary immunisation	246	141	86	473
B. Number of children who received a secondary (reinforcing) injection (i.e. subsequent to primary immunisation at an earlier age)	—	26	409	435

(b) *Whooping Cough.*—The Authority's scheme for immunisation against whooping cough takes the same lines as that for immunisation against diphtheria. Details of the number of children immunised against whooping cough are given in the following table:—

TABLE X

No. of children who received a full course of immunisation				
Under 6 months	6 months to 1 year	1 and under 2	2 and under 3	3 and under 4
16	148	49	8	4

Protection of School Children against Tuberculosis

(a) *Tuberculin Testing of School Entrants.*—Tuberculin testing was introduced in order that in the case of a positive result it would lead to a search for a source of infection and at the same time secure the placing of the child under medical supervision in order to avoid the risks which follow primary infection.

The following shows details of the work undertaken during the year under the provisions of the scheme for the routine tuberculin testing of school entrants:—

No. Invited	No. Refused	No. tested Elsewhere	No. Consented	Negative	Positive	Absentees
787	132	14	641	525	16	100

Of the 16 cases found positive 8 were X-rayed with negative results, 1 left the district, 2 had a family history of tuberculosis and were already under observation at the Chest Clinic and the remaining 5 are under review.

(b) *B.C.G. Vaccination.*—The scheme for the vaccination against tuberculosis of thirteen-year-old school children continued throughout the year, the details of the work undertaken are set out below:—

1. No. of Medical Officers approved to undertake B.C.G. Vaccination	1
2. *Acceptances*—	
No. of 13-year-old children eligible during the year	733
No. offered tuberculin testing and vaccination if necessary	733
No. found to have been vaccinated previously	2
No. of acceptances	217
Percentage of acceptances	29·68
3. *Pre-Vaccination Tuberculin Test*	
No. of children tested	215
Result of test—	
(i) Positive	50
(ii) Negative	165
(iii) Not ascertained	–
Percentage positive	23·25
4. *Vaccination*	
No. vaccinated	164
5. *Tuberculin test twelve months after vaccination*	
No. vaccinated in 1955	78
No. tuberculin tested after 12 months	72
Result of test—	
(i) Positive	61
(ii) Negative	11
(iii) Not ascertained	–

Co-operation of Teachers, Welfare Officers, Home Nurses and Voluntary Bodies

(a) *Teachers*

Teachers assist in the work of the School Medical Service by selecting children suffering from defects and referring them to the School Clinic.

(b) *Welfare Officers*

As usual, the Welfare Officers meet with mentally and physically defective children during the course of their home visits and greatly assist the School Medical Officer by referring them to the School Clinic.

(c) *Home Nursing Service*

The Home Nurses are always ready to assist where children require nursing treatment at home.

(d) *Voluntary Bodies*

(1) The Craven Branch of the National Society for the Prevention of Cruelty to Children

As in previous years, a high degree of co-operation has been maintained between the National Society for the Prevention of Cruelty to Children and this Department. By the pooling of knowledge and resources much can be done, and is done, to assist appropriate cases.

(2) The Keighley Infant Aid Society

The Keighley Infant Aid Society provides assistance in such cases as are appropriate to its sphere of activity.

Miscellaneous

Elementary Schools' Swimming 1956

Class Attendances		*Attendances by individuals on 3d. tickets*	
Boys	7,721	Boys	15,686
Girls	7,845	Girls	9,996

Results of Instruction

Preliminary Certificate ..	102
Elementary Certificate ..	276

The children passing for the Borough Elementary Swimming Certificate also receive a free pass to the Second Class Swimming Bath for twelve months.

Clinics

Particulars of Clinics held, showing day, time and frequency of sessions and staff in attendance, as at 31st December, 1956
See note at end of table for explanation of abbreviations.

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
DIV. 1. (SKIPTON)															
Addingham Mobile Clinic No. 1 ..	—	Thurs. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Barnoldswick The Butts .. .. .. (Phone: Barn'swick 3288)	Fri. p.m. ACMO/HV/M Wed. p.m. M *Relax.*	Wed. p.m./HV Thurs. p.m. ACMO/HV(2)	Wed. p.m. Fri. a.m. HV	—	Thurs. a.m. (alternate) ACMO/HV	—	—	—	—	—	as required HMO/HV	—	—	—	—
Barnoldswick Kelbrook Rd.	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Bradley Mobile Clinic No. 1 ..	—	Wed. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Carleton Mobile Clinic No. 1 ..	—	Thurs. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Cononley Mobile Clinic No. 1 ..	—	Wed. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Cowling Mobile Clinic No. 1 ..	—	Wed. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Crosshills Ebenezer Sunday School	Tues. a.m. (alternate) ACMO/HV/ M	Tues. p.m. (alternate) ACMO/HV(2) Tues. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Earby Old Grammar School ..	Fri. p.m. (alternate) ACMO/ HV(2)/M Tues. p.m. M *Relax.*	Wed. p.m. (alternate) GP/HV Wed. a.m. HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Embsay Mobile Clinic No. 1 ..	—	Thurs. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Gargrave The Institute	—	Thurs. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Grassington Church House	—	Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Silsden Kirkgate Methodist Sunday School	—	Tues. p.m. (alternate) ACMO/HV(2) Thurs. p.m. (alternate) HV	—	—	Tues. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Skipton Millfields Hall	—	Wed. p.m. ACMO/HV(2) Thurs. p.m. HV(2)	—	—	Fri. a.m. (alternate) ACMO/HV	—	—	—	—	—	as required HMO/HV	—	—	—	—
DIV. 2 (SETTLE)															
Austwick Mobile Clinic No. 1 ..	—	Tues. p.m. (every 4 weeks) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Bentham .. Town Hall	—	Tues. p.m. (alternate)	—	—	—	—	—	—	—	—	—	—	—	—	—

Ashfield House	(alternate) M *Relax.*															
Bolton-by-Bowland Mobile Clinic No. 1 ..	—	Mon. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Burton-in-Lonsdale Mobile Clinic No. 1 ..	—	Tues. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Clapham Mobile Clinic No. 1 ..	—	Tues. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Grindleton Mobile Clinic No. 1 ..	—	Mon. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Grindleton Riversmead School .	—	—	—	—	—	—	—	—	—	—	as required HMO/HV	—	—	—	—	—
Hellifield Mobile Clinic No. 1 ..	—	Mon. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Helwith Bridge Mobile Clinic No. 1 ..	—	Tues. p.m. (every 4 weeks) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Horton-in-Ribblesdale Mobile Clinic No. 1 ..	—	Tues. p.m. (every 4 weeks) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Ingleton Literary Institute ..	—	Tues. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	as required HMO/HV	—	—	—	—	—
Long Preston Mobile Clinic No. 1 ..	—	Mon. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Sedbergh Masonic Hall	—	Wed. p.m. (1st & 3rd) ACMO/HV/M	—	—	—	—	—	—	—	—	as required HMO/HV	—	—	—	—	—
Settle Wesleyan Sunday School	—	Thurs. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	as required HMO/HV	—	—	—	—	—
Settle Divisional Office, Cragdale	Tues p.m. (alternate) ACMO/HV/ M	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Waddington St. Helen's Sunday School	—	Thurs. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 3 (KEIGHLEY)																
Haworth Hall Green Baptist Church	Wed. a.m. ACMO/HV/M Wed. p.m. M *Relax.*	Tues. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Haworth The Institute	—	—	—	—	—	—	—	—	Tues. p.m. ON	—	—	—	—	—	—	—
Keighley Westgate Clinic, Oakworth Road .. .. .. (Phone: Keighley 2244/5)	Tues. p.m. ACMO/HV/ M Fri. a.m. ACMO/HV Wed. p.m. M *Relax.*	Thurs. p.m. DMO/HV(2) Fri. p.m. DMO/HV(2)	—	—	—	—	Mon. p.m. (last in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—
Keighley Mansion House, Victoria Park .. .. .. (Phone: Keighley 2244/5)	Tues. a.m. ACMO/HV/M Tues. p.m. M *Relax.*	Wed. a.m.HV(2) Wed. p.m. ACMO/HV(2)	—	—	—	—	Mon. p.m. (1st in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Keighley 147 Skipton Road ..	—	—	Wed. a.m. Sat. a.m. ON	Daily a.m. HV	Mon. a.m. Thurs. a.m. Sat. a.m. ACMO/HV	Mon. a.m. Tues. p.m. Wed. a.m. Fri. a./p.m. ST	Fri. p.m. (last in mth.) ACMO/HV	—	Mon.a./p.m. Tues. a.m. Wed. p.m. Th. a./p.m. Fri. p.m. ON	—	Tues. a.m. (alternate) HMO/HV	—	—	Daily	—
Oakworth Methodist Sunday School	Thurs. p.m. (alternate) before I.W. ACMO/HV/M	Thurs. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Oxenhope Methodist Sunday School	Thurs. p.m. (alternate) before I.W. ACMO/HV/M	Thurs. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Morton Memorial Institute, East Morton	—	Fri. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 4 (SHIPLEY)															
Baildon Methodist School ..	Wed. a.m. (alternate) GP/HV/M	Mon. p.m. GP/HV(2)	—	Mon. a.m. H.V.	—	—	—	—	—	—	—	—	—	—	—
Bingley County Secondary School	—	—	—	At S.C.	Fri. am. ACMO/HV	—	—	—	—	—	—	—	—	—	—
Bingley Myrtle Park .. .. (Phone: Bingley 3894)	Tues. p.m. ACMO/M(2) Wed. p.m. M/HV *Relax.*	Thurs. p.m. ACMO/HV(2)	—	Tues. a.m. Thurs. a.m. HV	Fri. p.m. ACMO/HV	Mon. p.m. ST	—	—	Mon. p.m. ON	—	—	—	—	—	—
Bingley Old Technical Institute ..	—	—	Mon. p.m. Fri. p.m. HV	—	—	—	—	—	—	—	—	—	—	Daily	—
Cottingley Town Hall	—	Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Cullingworth Church School	—	Tues. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Denholme Methodist School ..	With Infant Welfare	Wed. p.m. (alternate) GP/HV/M	—	—	—	—	—	—	—	—	—	—	—	—	—
Harden (Bingley) Memorial Hall	—	Wed. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Shipley Somerset House .. .. (Phone: Shipley 51363)	Tues. p.m. M(2) Wed. p.m. ACMO/M(2) Tues. p.m. M/ON *Relax.*	Tues. p.m. ACMO/HV(3) Thurs. p.m. ACMO/HV(2)	Wed. a.m. Sat. am. HV	Tues. a.m. Thurs. a.m. HV	Thurs. p.m. ACMO/HV	Tues. a.m. Thurs. a./p.m. ST	Thurs. a.m. ACMO/HV	Fri. a./p.m. Ps/Pl/PSW	Tues. p.m. Wed. a.m. Thurs. p.m. and Fri. a.m. (alternate) ON	—	Thurs. a./ p.m. HMO/HV	Mon. p.m. (monthly) HMO/ON	—	Daily	— E.N.T. Tues. a.m. (monthly) HMO/HV Dermato- logical Mon. a.m. (monthly) HMO/HV Audiometry Fri. p.m. HV
Shipley 105 Wrose Road .. (Phone: Shipley 54237)	—	Tues. a.m. HV Fri. p.m. ACMO/HV(2)	—	Fri. a.m. HV	—	—	—	—	—	—	—	—	—	—	—

Shipley Maternity Home	Wed. a.m. ACMO	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Wilsden Royd House	—	Tues. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 5 (HORSFORTH)															
Calverley Chapel Street .. .. (Phone: Pudsey 2407)	Wed. p.m. (1st in month with IW) GP/HV(3)/M Mon. p.m. M *Relax.*	Wed. p.m. GP/HV(2)	Wed. a.m. Fri. a.m. HV	—	—	—	—	—	—	—	—	—	—	—	—
Farsley Farfield House	Fri. p.m. GP/HV(2)/M Wed. p.m. (except 1st) M *Relax.*	Tues. p.m. GP/HV(2)	—	Mon. a.m. Thurs. a.m. HV	—	—	—	—	—	—	Wed. a./p.m. (2nd in mth.) HMO/HV	—	Thurs. a.m. (1st in mth.) HMO/HV	—	E.N.T. Tues. a.m. (1st in mth.) HMO/HV
Guiseley Baptist Church, Oxford Road	Wed. p.m. ACMO/HV/M Wed. p.m. M *Relax.*	Thurs. p.m. ACMO/HV(2)	—	Thurs. a.m. HV(2)	Thurs. a.m. (1st & 4th) ACMO/ HV(2)	Mon. a.m. Wed. a.m. ST	—	—	—	—	as required HMO/HV	—	Thurs. a.m. (3rd in mth.) HMO/HV	—	—
Horsforth St. Margaret's Hall ..	Mon. p.m. (1st & 3rd) GP/HV/M Tues. p.m. M *Relax.*	Wed. p.m. GP/HV(2)	—	Wed. a.m. HV(2)	Wed. a.m. (4th in mth.) ACMO/ HV(2)	—	—	—	—	—	—	—	—	—	—
Pudsey St. Lawrence House ..	Thurs. p.m. ACMO/ HV(3)/M	Mon. p.m. GP/HV(2) Wed. p.m. HV	Tues. a.m. Thurs. a.m. HV	Tues. a.m. Wed. a.m. Fri. a.m. HV	Tues. a.m. (except 1st) ACMO/HV	Tues. a.m. Wed. p.m. Th. a./p.m. (alternate) ST	—	—	Mon. a.m. Wed. p.m. Sat. a.m. (alternate) ON	—	—	Fri. a.m. (3rd in mth.) HMO/ON	—	—	—
Pudsey Richardshaw Lane ..	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Rawdon Methodist Sunday School, Harrogate Road	Wed. a.m. (2nd in mth.) GP/HV(2)/M	Thurs. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Yeadon Town Hall	Wed. a.m. (1st & 3rd) GP/HV(2)	Tues. p.m. ACMO/HV(2)	—	Tues. a.m. HV	Tues. a.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—
Yeadon South View School ..	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
DIV. 6 (OTLEY)															
Bramhope Craven Institute	—	Mon. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Burley The Grange .. .. (Phone: Burley 2289)	Wed. p.m. M/HV *Relax.*	Tues. p.m. ACMO/HV	—	Daily HV	—	—	—	—	—	—	—	—	—	—	—
Ilkley South Hawksworth Street (Phone: Ilkley 1606)	Thurs. p.m. (alternate) HV Thurs. p.m. M/HV *Relax.*	Wed. p.m. GP/HV	Tues. p.m. Fri. p.m. HV	Daily a.m. HV	Mon. a.m. ACMO/HV	Fri. a.m. ST	—	—	Thurs. a.m. ON	—	Mon. a./p.m. (3rd in mth.) HMO/HV	—	—	—	—
Menston Kirklands	—	Thurs. p.m. (alternate) GP/HV	—	Mon. a.m. Fri. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Otley The Licks .. .. .. (Phone: Otley 2727)	Tues. p.m. M Tues. a.m. ON/HV *Relax.*	Thurs. p.m. ACMO/HV	Mon. a.m. Fri. a.m. HV	Daily a.m. HV	Thurs. a.m. ACMO/ HV	—	—	—	Fri. p.m. ON	—	Mon. a./p.m. (1st in mth.) HMO/ HV	—	—	—	—

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Ortho-paedic	Paedi-atric	Dental	Other
Otley Whiteley Croft	—	—	—	—	—	Mon. p.m. Fri. p.m. ST	—	—	—	—	—	—	—	—	—
Pool-in-Wharfedale Church Room	—	Mon. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	— Cardiac see Div. 8
DIV. 7 (RIPON)															
Birstwith Mobile Clinic No. 1 ..	—	Mon. p.m. (4 weekly) DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Bishop Monkton Mobile Clinic No. 1 ..	—	Fri. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Bishop Thornton Mobile Clinic No. 1 ..	—	Mon. a.m. (4 weekly) DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Copt Hewick Mobile Clinic No. 1 ..	—	Tues. p.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Dacre Mobile Clinic No. 1 ..	—	Mon. p.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Darley Mobile Clinic No. 1 ..	—	Mon. p.m. (alternate) DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Galphay Mobile Clinic No. 1 ..	—	Tues. a.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Grewelthorpe Mobile Clinic No. 1 ..	—	Tues. a.m. (4 weekly) ACMO/HV	—	—	—	—	—		—	—	—	—	—	—	—
Kirkby Malzeard Mobile Clinic No. 1 ..	—	Tues. a.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Lofthouse Mobile Clinic No. 1 ..	—	Mon. a.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Markington Mobile Clinic No. 1 ..	—	Mon. a.m. (4 weekly) DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Mickley Mobile Clinic No. 1 ..	—	Tues. a.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
North Stainley Mobile Clinic No. 1 ..	—	Tues. p.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Nunwick Mobile Clinic No. 1 ..	—	Tues. p.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Pateley Bridge Methodist Buildings ..	—	Wed. p.m. (1st & 3rd) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Pateley Bridge Welfare Centre, Council Offices	—	—	—	—	Fri. a.m. ACMO/HV	—	—	—	—	—	As required HMO/HV	—	—	—	—
Ripon Alma House .. .. (Phone: Ripon 919)	Thurs. p.m. GP/HV(2)	Mon. p.m. ACMO/HV(2)	Mon. a.m. ACMO/HV Thurs. a.m. DMO/HV	Daily a.m. HV(2)	Mon. a.m. ACMO/ HV(2)	Wed. a.m. Fri. a./p.m. ST	—	—	—	—	Tues. p.m. HMO/HV	Fri. p.m. (3rd in mth.) HMO/HV	Fri. p.m. (2nd in mth.) HMO/ HV(2)	Daily	—

															(1st in mth.) HMO/HV
Sawley Mobile Clinic No. 1 ..	—	Tues. a.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Shaw Mills Mobile Clinic No. 1 ..	—	Mon. a.m. (4 weekly) DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Skelton Mobile Clinic No. 1 ..	—	Tues. p.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Summerbridge Methodist Buildings ..	—	Wed. p.m. (2nd in month) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Winksley Mobile Clinic No. 1 ..	—	Tues. a.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 8 (HARROGATE)															
Boroughbridge Methodist Sunday School	—	Fri. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Burton Leonard Mobile Clinic No. 1 ..	—	Fri. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Follifoot Mobile Clinic No. 1 ..	—	Fri. a.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Hampsthwaite Mobile Clinic No. 1 ..	—	Fri. a.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Harrogate Dragon Parade .. .. (Phone: Harrogate 6332)	Tues. p.m. Wed. a.m. ACMO/HV Tues. p.m. Wed. a.m. HV *Relax. & Mothercraft*	Mon. p.m. Thurs. p.m. ACMO/HV(2)	Mon. a.m. Wed. p.m. Fri. a.m. HV	Mon. a.m. Thurs. a.m. DMO/HV	Wed. p.m. DMO/HV	Mon. p.m. Tues. a.m. Wed. p.m. ST	Wed. a.m. ACMO/HV	—	—	Mon. a.m. Fri. a.m. MH	—	Tues. a.m. (alternate) HMO/ ACMO/HV	—	Daily	E.N.T. Tues. a.m. (alternate) HMO/HV
Harrogate 11 Ripon Road, ... (Hospital premises)	—	—	—	—	—	—	—	—	—	—	Fri. a./p.m. (1, 2 & 4th) HMO/HV	—	—	—	—
Harrogate General Hospital ..	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Cardiac Sat. a.m. HMO/ ACMO/HV includes Divs. 7 & 9
Harrogate Methodist School Room, High St., Starbeck ..	—	Wed. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Harrogate St. Joseph's Schoolroom, Skipton Road	—	Mon. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Harrogate Penny Pot Lane .. .. (Army premises)	—	Wed. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Killinghall Mobile Clinic No. 1 ..	—	Fri. a.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Knaresborough Fysche Hall .. .. (Phone: Knaresborough 3014)	—	Tues. p.m. ACMO/HV Thurs. p.m. (2nd & 4th) HV	—	—	Mon. a.m. Thurs. a.m. ACMO/HV	—	—	—	—	Mon. p.m. Fri. p.m. MH	Fri. a./p.m. (3rd in mth.) HMO/HV	—	—	—	—

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Poppleton Church Hall	—	Wed. p.m. (2nd & 4th) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Whixley Village Hall	—	Thurs. p.m. (1st & 3rd) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 9 (WETHERBY)															Cardiac See Div. 8
Appleton Roebuck Mobile Clinic No. 1 ..	With Infant Welfare	Thurs. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Barwick-in-Elmet Methodist Schoolroom ..	With Infant Welfare	Tues. p.m. (alternate) GP/HV(2) Tues. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Boston Spa West End Nursery School	With Infant Welfare	Wed. p.m. (alternate) ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Bramham Mobile Clinic No. 1 ..	With Infant Welfare	Fri. a.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Copmanthorpe Mobile Clinic No. 1 ..	With Infant Welfare	Thurs. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Church Fenton Methodist Sunday School	With Infant Welfare	Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Church Fenton R.A.F. Station	With Infant Welfare	Thurs. p.m. (alternate) MO(RAF)/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
East Keswick Mobile Clinic No. 1 ..	With Infant Welfare	Fri. a.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Huby Mobile Clinic No. 1 ..	With Infant Welfare	Fri. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Ledston Mobile Clinic No. 1 ..	With Infant Welfare	Wed. a.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Micklefield Methodist Chapel	With Infant Welfare Tues. p.m. (alternate) M *Relax.*	Tues. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Scholes Mobile Clinic No. 1 ..	With Infant Welfare	Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Sherburn-in-Elmet Methodist Sunday School	With Infant Welfare	Tues. p.m. (alternate) GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Swarcliffe Estate Mobile Clinic No. 1 ..	With Infant Welfare	Wed. a.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Swillington Clinic Hut, Wakefield Rd.	With Infant Welfare	Thurs. p.m. GP/HV	—	Wed. a.m. HV	—	—	—	—	—	—	—	—	—	—	—

Tadcaster Multiple Clinic, Leeds Rd. (Phone: Tadcaster 3260)	Wed. a.m. (alternate) Fri. p.m. (alternate) DMO/HV(2)/M Fri. p.m. (alternate) HV *Relax.*	Tues. p.m. (alternate) ACMO/HV(2)	—	Tues. a.m. Thurs. a.m. HV		Thurs.a./p.m. ST				Wed. a./p.m. MH	(alternate) HMO/HV	(1st in mth.) HMO/HV	(2nd in mth.) HMO/HV		Tues. a.m. (4 weekly) HMO/HV
Thorner Mobile Clinic No. 1 ..	With Infant Welfare	Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Tockwith Methodist Sunday School	With Infant Welfare	Mon. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Wetherby Crossley Street .. .. (Phone: Wetherby 551)	Wed. p.m. (alternate) ACMO/HV (2)/M	Thurs. p.m. ACMO/HV(2)	—	Thurs. a.m. HV	—	Tues. p.m. ST	—	—	—	—	Fri. p.m. (alternate) HMO/HV	—	—	Daily	—
DIV. 10 (GOOLE)															
Goole Bartholomew Ave. .. (Phone: Goole 490)	Fri. p.m. DMO/ACMO/HV(3) Mon. p.m. HV/M *Relax.*	Tues. p.m. ACMO/HV(3)	Mon. a.m. Thurs. a.m. HV	Mon. a.m. Wed. a.m. Fri. a.m. HV	Fri. a.m. ACMO/HV (2)	Wed. p.m. Thurs. p.m. ST	—	—	Tues. a.m. Thurs. a.m. ON	Mon. a.m. Wed.a./p.m. Thurs. a.m. Fri. a.m. MH	Thur.a./p.m. As required HMO/HV	Tues. a.m. (2nd in mth.) HMO/HV	Wed. p.m. (1st in mth.) HMO/HV	—	—
Goole Westfield Avenue.. ..	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Old Goole St. Mary's Hall	—	Thurs. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Selby Brook Street	Mon. p.m. ACMO/HV(2) Wed. p.m. HV/M *Mothercraft*	Fri. p.m. ACMO/HV(2)	—	Mon. a.m. Fri. a.m. HV	Mon. a.m. ACMO/HV (2)	—	—	—	Tues. p.m. ON	—	Thurs. a./p.m. As required HMO/HV	—	—	—	—
Selby Hawdon Institute, Church Avenue	—	—	—	—	—	Wed. a.m. ST	—	—	—	Tues.a./p.m. MH	—	—	—	—	—
Snaith Rose Cottage	Wed. p.m. (alternate) ACMO/HV	Thurs. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Swinefleet Prospect House	Wed. p.m. (alternate) ACMO/HV(2) Wed. p.m. (alternate) HV/M *Mothercraft*	Mon. p.m. ACMO/HV(2)	—	Mon. a.m. Wed. a.m. HV	Wed. a.m. (alternate) ACMO/HV	—	—	—	—	Thurs. p.m. MH	—	—	—	—	—
DIV. 11 (CASTLEFORD)															
Airedale Methodist Church ..	Thurs. p.m. (1, 2 & 4) GP/HV(2)/M(2)	Mon. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Altofts Upper Altofts Methodist Church	—	Wed. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Castleford Castledene .. .. (Phone: Castleford 2689)	Tues. p.m. M *Relax.*	—	Tues. a.m. Fri. a.m. HV(2)	—	—	Tues.a./p.m. Fri. a./p.m. ST	—	—	—	—	Wed. a./p.m. HMO/HV	Tues. a.m. (4th in mth.) HMO/HV	Wed. p.m. (3rd in mth.) HMO/HV	—	—
Castleford Barnes Road	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Castleford West Villa, Hightown .. (Phone: Castleford 3549)	Thurs. p.m. GP/HV/M(2)	Mon. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Castleford Hightown Hospital ..	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Wed. p.m. (alternate) HMO/HV
Castleford Old Council Offices, Sagar Street .. (Phone: Castleford 3551)	Wed. p.m. GP/HV(2)/ M(2)	Mon. p.m. Thurs. p.m. GP/HV(2)	—	Mon. a.m. Wed. a.m. Fri. a.m. HV	Wed. a.m. ACMO/ HV(2)	—	—	—	—	—	—	—	—	—	—
Glasshoughton St. Paul's Church ..	Wed. p.m. (2nd & 4th) GP/HV/M	Tues. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Normanton Park Pavilion .. .. (Phone: Normanton 3292)	Wed. p.m. ACMO/HV/ M(2)	Tues. p.m. Thurs. p.m. ACMO/HV(2)	Tues. p.m. Fri. p.m. HV(2)	Daily a.m. HV	Tues. a.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—
DIV. 12 (PONTEFRACT)															
Beal Methodist Chapel ..	—	Thurs. p.m. (alternate) DMO/HV/	—	—	—	—	—	—	—	—	—	—	—	—	—
Brotherton Mobile Clinic No. 2 ..	—	Mon. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Carleton Community Centre ..	—	Wed. p.m. DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Fairburn Mobile Clinic No. 2 ..	—	Mon. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Featherstone Albert Street .. .. (Phone: Featherstone 330)	Tues. p.m. ACMO/HV/ M(3) Mon. p.m. M(2) *Relax.*	Wed. p.m. ACMO/HV(2) Thurs. p.m. (2nd & 4th) GP/HV, *Toddlers*	—	Daily a.m. HV	Mon. a.m. (1st & 3rd) ACMO/HV	Mon. a./p.m. ST	Thurs. a.m. (1st in mth.) ACMO/HV	—	—	Mon. p.m. Tues. a.m. MH	—	—	—	—	—
Ferrybridge Wesleyan Chapel ..	Tues. p.m. (alternate) ACMO/HV/ M(2)	Wed. p.m. GP/HV(3)	—	Wed. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Hensall Mobile Clinic No. 2 ..	—	Tues. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Knottingley Chapel Street	Tues. p.m. (2nd & 4th) GP/HV/M(2) Thurs. p.m. (1st & 3rd) GP/HV/M(2) Fri. p.m. M(2) *Relax.*	Mon. p.m. GP/HV(3)	—	Mon. a.m. Fri. a.m. HV	Mon. a.m. (2nd & 4th) ACMO/ HV(2)	Thurs. a.m. ST	—	—	—	Wed. p.m. Fri. p.m. MH	—	—	—	—	—
Knottingley Racca Green	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Monk Fryston Mobile Clinic No. 2 ..	—	Mon. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—

Pontefract Headlands Road .. .. (Phone: Pontefract 2577)	Fri. a.m. DMO/HV/ M(2) Tues. p.m. M *Relax.*	Mon. a./p.m. ACMO/HV	Tues. a.m. Fri. a.m. HV	Daily HV	Mon. a./p.m. Thurs. a./p.m. ACMO/HV		1st & 3rd (2nd & 4th) DMO/HV		ON	Thurs. p.m. MH	HMO/HV	(1st in mth.) HMO/ON			Wed. p.m. (alternate) HMO/HV
Streethouse Methodist Chapel ..	—	Mon. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Whitley Bridge Mobile Clinic No. 2 ..	—	Tues. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 13 (MORLEY)															
Crigglestone Village Institute	With Infant Welfare	Wed. p.m. ACMO/HV/M	—	Wed. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Crofton Mission Hall	With Infant Welfare	Mon. p.m. ACMO/HV/M	—	—	—	—	—	—	—	—	—	—	—	—	—
Crofton Parochial Hall	—	—	—	Mon. a.m. Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Drighlington Methodist School ..	Thurs. p.m. (2nd & 4th)	Fri. p.m. GP/HV	—	Tues. p.m. Fri. p.m. HV	—	—	—	—	—	—	—	—	—	—	—
East Ardsley Methodist School, The Falls	With Infant Welfare	Tues. p.m. GP/HV	—	Tues. p.m. Fri. p.m. HV	—	—	—	—	—	—	—	—	—	—	—
Gildersome Council Offices	Thurs. p.m. (1st & 3rd) M *Relax.*	Wed. p.m. ACMO/HV	—	Mon. p.m. Wed. p.m. HV	—	—	—	—	—	—	—	—	—	—	—
Horbury Congregational School, Tithe Barn Street ..	Thurs. p.m. ACMO/M	Mon. p.m. GP/HV	—	Mon. a.m. Thurs. a.m. HV	Thurs. a.m. (1st in mth.) ACMO/ HV(2)	—	—	—	—	—	—	—	—	—	—
Middlestown Church School	With Infant Welfare	Tues. p.m. ACMO/HV/M	—	—	—	—	—	—	—	—	—	—	—	—	—
Morley Corporation Street .. (Phone: Morley 1570)	Fri. p.m. ACMO/M(2) Mon. p.m. M(2) *Relax.*	Mon. p.m. Wed. p.m. ACMO/HV(2)	Tues. p.m. Thurs. p.m. HV	Daily a./p.m. HV	Tues. a.m. Fri. a.m. ACMO/HV	Fri. a./p.m. ST	Fri. a.m. ACMO/HV	—	—	—	2/3 monthly As required HMO/HV	—	Wed. p.m. (2nd & 4th) HMO/HV	Daily	—
Ossett Croft House .. .. (Phone: Ossett 33)	Fri. p.m. ACMO/ M(3) Wed. p.m. M *Relax.*	Mon. p.m. GP/HV(2) Thurs. p.m. ACMO/HV(2)	—	—	Tues. a.m. Fri. a.m. ACMO/HV	Mon. a./p.m. Wed. a.m. ST	Wed., (1st for under 5's and 2nd for over 5's) GP/HV	—	—	—	Mon.a./p.m. (2nd in mth.) HMO/HV	—	—	Daily	—
Sharlston St. Luke's Hall	With Infant Welfare	Tues. p.m. ACMO/HV/M	—	Tues. a.m. Fri. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Wakefield Central Dental Clinic, Bond Street	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Wakefield County Health Department	—	—	—	—	—	—	—	Wed. a./p.m. Ps/Pl/PSW	—	—	Mon. a./p.m. Fri. a./p.m. As required HMO/HV	—	—	—	—
Wakefield Pinderfields Hospital ..	—	—	—	—	—	—	—	—	—	—	—	Wed. p.m. (monthly) HMO/ON Includes Div. 16	—	—	—

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Ortho-paedic	Paedi-atric	Dental	Other
West Ardsley 1 Syke Lane	Thurs. p.m. (1st & 3rd) ACMO/M Mon. p.m. M(2) *Relax.*	Thurs. p.m. ACMO/HV	—	Mon. p.m. Wed. p.m. Thurs. p.m. HV	—	—	—	—	—	—	—	—	—	—	—
DIV. 15 (BATLEY)															
Batley Wellington Street .. .. (Phone: Batley 664)	Mon. p.m. ACMO/HV/M(2)	Fri. p.m. ACMO/HV(3)	Mon. a.m. Thurs. a.m. HV	Tues. a.m. Wed. a.m. Fri. a.m. HV	Mon. a.m. Thurs. a.m. ACMO/HV	Wed. a./p.m. ST	Fri. p.m. ACMO/HV	—	—	—	Wed. a.m. HMO Fri. a./p.m. (alternate) HMO/HV	—	Mon. a.m. (alternate) HMO/HV	—	—
Batley Market Place	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Batley Temperance Hall ..	—	—	—	—	—	—	—	—	Mon. a./p.m. Thurs. a./p.m. ON	—	—	Mon. a.m. (2nd in mth.) HMO/ON	—	—	—
Batley Carr King Street Mission ..	—	Thurs. p.m. (alternate) ACMO/HV(2)	—	—	—	—	Thurs. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—
Birstall St. John's Methodist Sunday School	—	Wed. p.m. ACMO/HV(3)	—	Wed. p.m. HV	—	—	Wed. p.m. ACMO/HV	—	—	—	—	—	—	—	—
Hanging Heaton Church Hall, Ebenezer Methodist Chapel ..	—	Thurs. p.m. (alternate) ACMO/HV(2)	—	—	—	—	Thurs. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—
Heckmondwike The Hollies, Cemetery Rd. (Phone: Heckmondwike 1074)	Wed. p.m. (alternate) ACMO/M(2)	Thurs. p.m. ACMO/HV(2) Wed. p.m. (alternate) ACMO/HV *Toddlers*	—	Daily a.m. except Wed. HV	Wed. a.m. DMO/HV	—	Wed. a.m. ACMO/HV	—	—	—	—	—	—	—	—
Staincliffe Methodist Sunday School	—	Tues. p.m. ACMO/HV(2)	—	—	—	—	Tues. p.m. ACMO/HV	—	—	Tues. p.m. MH	—	—	—	—	—
DIV. 16 (ROTHWELL)												See Div. 13			
Allerton Bywater Miners' Welfare Institute	—	Wed. p.m. (alternate) ACMO/HV Wed. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Garforth Brunswick Methodist Chapel	Mon. p.m. ACMO/HV/M Fri. p.m. M *Relax.*	Mon. a.m. (alternate) ACMO/HV Mon. a.m. (alternate) HV	Mon. p.m. Wed. p.m. Fri. p.m. HV	—	—	—	—	—	—	—	—	—	—	—	—
Kippax Methodist Chapel, Chapel Lane	Tues. a.m. ACMO/HV/M	Tues. p.m. (alternate) ACMO/HV Tues. p.m. HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Lofthouse Wesleyan Chapel School-room, Leeds Road ..	—	Mon. p.m. (alternate) ACMO/HV Mon. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—

Red House	(alternate) ACMO/HV/M	(alternate) ACMO/HV Wed. p.m. (alternate) HV													
Oulton Harold Hall Institute, Quarry Hill	—	Tues. p.m. (alternate) ACMO/HV Tues. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Outwood Church Institute, Leeds Road	Wed. a.m. (alternate) ACMO/HV/M Wed. p.m. M *Relax.*	Wed. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Rothwell Oulton Lane .. .. (Phone: Rothwell 2326)	Thurs. a./p.m. DMO/HV/M Tues. p.m. M *Relax.*	Mon. p.m. DMO/HV	Mon. a.m. Wed. a.m. Fri. a.m. HV	—	—	Tues. a./p.m. Wed. p.m. ST	—	—	—	—	Fri. a./p.m. (1st & 3rd) HMO/HV	—	Fri. a.m. (2nd in mth.) HMO/HV	—	E.N.T. As required HMO/HV
Rothwell Carlton Lane	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Stanley Zion Congregational Chapel, Aberford Road	Thurs. a.m. (alternate) ACMO/HV/M	Thurs. p.m. ACMO/HV Mon. p.m. HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Thorpe Women's Institute ..	—	Wed. a.m. (alternate) ACMO/HV Wed. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Wrenthorpe St. Anne's Church Rooms	Mon. p.m. ACMO/HV/M	Mon. p.m. (alternate) ACMO/HV Mon. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 17 (SPENBOROUGH)															
Birkenshaw Old Lane	Wed. p.m. (1st & 3rd) ACMO/HV/M	Tues. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Cleckheaton Elm Bank .. .. .. (Phone: Cleckheaton 844)	Thurs. p.m. ACMO/HV/M(2) Thurs. p.m. M *Relax.*	Wed. p.m. ACMO/HV(2) Wed. p.m. (alternate) HV(2) *Mothers*	—	—	Mon. a.m. ACMO/HV	—	—	—	Fri. a./p.m. ON	—	Mon. p.m. Tues. p.m. HMO/HV	—	Mon. a.m. (alternate) HMO/HV	Daily	Chiropody Thurs. a.m. Ch
Gomersal Public Hall	—	Fri. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Liversedge Valley Road .. .. (Phone: Heckmondwike 839)	Mon. p.m. ACMO/HV/M(2)	Tues. p.m. ACMO/HV(2)	Tues. a.m. Sat. a.m. HV	—	—	Thur.a./p.m. ST	—	—	—	Wed. p.m. MH	—	—	—	—	Chiropody Mon. a.m. Ch
Mirfield Ings Grove .. .. (Phone: Mirfield 2376)	Wed. p.m. (2nd & 4th) ACMO/HV/M Wed. p.m. M *Relax.*	Thurs. p.m. (1st in mth.) ACMO/HV *Toddlers* Fri. p.m. ACMO/HV(2)	Wed. p.m. Sat. a.m. HV	—	Fri. a.m. ACMO/HV	—	—	Tues. a./p.m. Ps/PSW	Wed. a.m. ON	—	As required HMO/HV	—	—	—	Chiropody Fri. a.m. Ch

CLINICS—(*continued*)

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Roberttown Sunday School	—	Thurs. p.m. (3rd in month) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Scholes Temperance Hall ..	—	Thurs. p.m. (2nd & 4th) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 18 (BRIGHOUSE)															
Brighouse Bonegate House	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Brighouse 10 Huddersfield Road ..	Tues. p.m. (alternate) ACMO/HV/M	Wed. p.m. GP/HV(2) Thurs. p.m. DMO/HV	—	—	—	—	Fri. a.m. As required DMO/HV	—	—	—	—	—	—	—	—
Brighouse Atlas Mill Road	Tues. p.m. Fri. p.m. HV *Relax.*	—	Mon. a.m. Thurs. a.m. HV	Daily HV	Thurs. a.m. ACMO/HV	—	—	—	—	—	Thurs. a.m. (alternate) Fri. a.m. HMO/HV	Fri. p.m. (monthly) HMO/HV	—	—	E.N.T. Mon. a.m. As required HMO/HV
Elland St. Paul's School	Mon. p.m. (alternate) DMO/HV/M Mon. p.m. HV *Relax.*	Wed. p.m. ACMO/HV(2)	Mon. a.m. Wed. a.m. HV	Mon. a.m. Wed. a.m. HV	Wed. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Greetland Clay House .. .. (Phone: Elland 2540)	Wed. p.m. (alternate) ACMO/HV/M	Tues. p.m. GP/HV(2)	Mon. p.m. Thurs. p.m. HV	Tues. a.m. Thurs. a.m. HV	Tues. a.m. (3rd in mth.) ACMO/HV	—	—	—	—	—	Thurs. a.m. (alternate) HMO/HV	—	—	—	—
Hipperholme Wesleyan School .. .. (Phone: Halifax 69787)	Fri. p.m. (alternate) ACMO/HV/M Fri. p.m. (alternate) M *Relax.*	Mon. p.m. ACMO/HV(2)	Mon. a.m. Fri. a.m. HV	—	Mon. a.m. DMO/HV	—	—	—	—	—	—	—	—	—	—
Qucensbury Station Road	Fri. p.m. (alternate) ACMO/HV/M Fri. p.m. (alternate) M *Relax.*	Tues. p.m. ACMO/HV(2)	Tues. a.m. Fri. a.m. HV	Tues. a.m. Fri. a.m. HV	Fri. a.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Shelf Witchfield Chapel ..	Mon. p.m. ACMO/HV/M	Mon. p.m. ACMO/HV	Mon. a.m. HV	Mon. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Southowram St. Anne's in the Grove .. (Phone: Halifax 3521)	Thurs. p.m. ACMO/HV/M	Thurs. p.m. ACMO/HV(2)	Mon. a.m. Thurs. a.m. HV	Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
DIV. 19 (TODMORDEN)															
Hebden Bridge Pitt Street .. .. .. (Phone: Hebden Bridge 324)	Fri. p.m. ACMO/HV/M(2) Tues. p.m. M(2) *Relax.*	Wed. p.m. ACMO/HV(2) Thurs. p.m. HV(2)	Mon. p.m. Thurs. a.m. HV(2) Oct.—Apl.	—	Wed. a.m. ACMO/HV	Tues. a.m. ST	—	—	—	—	As required HMO/HV	—	—	—	—
Luddendenfoot The Institute	Fri. a.m. (1st & 3rd) ACMO/HV/M	Fri. p.m. ACMO/HV	—	Fri. a.m. HV	—	—	—	—	—	—	—	—	—	—	—

Scout Road Methodist Sunday School		(alternate) GP/HV Wed. p.m. (alternate) HV													
Ripponden Zion Congregational Sunday School	Tues. p.m. (1st in month) ACMO/HV/M	Tues. p.m. (1st & 3rd) ACMO/HV Tues. p.m. (other) HV	—	Tues. a.m.	—	—	—	—	—	—	—	—	—	—	—
Sowerby Bridge Allan House .. .. (Phone: Halifax 82063)	Mon. p.m. ACMO/ HV(2)/M	Thurs. p.m. ACMO/HV(2)	Tues. a.m. Fri. p.m. HV Oct.—Apl.	—	Mon. a.m. ACMO/HV	Fri. a./p.m. ST	—	—	—	Mon. p.m. Tues. p.m. Thurs. a.m. Fri. a.m. MH	As required HMO/HV	—	—	—	—
Todmorden Abraham Ormerod Medical Centre .. .. (Phone: Todmorden 382)	Wed. a.m. GP/HV Wed. p.m. GP/HV/M(2) Wed. p.m. M *Relax.*	Tues. p.m. HV Wed. p.m. ACMO/HV	Mon. p.m. Thurs. p.m. HV Oct.—Apl.	Daily p.m. except Wed. HV	Wed. p.m. ACMO/HV	Tues. p.m. ST	—	—	Mon. p.m. Thurs. a.m. HV/ON Mon. a.m. Thurs. p.m. ON	Tues. a.m. Wed. a./p.m. Fri. p.m. MH	As required HMO	Wed. a.m. (bi-monthly) HMO/ON/ HV	—	Daily	E.N.T. As required Mon. a.m. HMO/HV
Todmorden Vale Baptist Sunday School, Cornholme ..	—	Tues. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Todmorden Walsden Wesley Sunday School	—	Thurs. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 20 (COLNE VALLEY)															
Delph Independent Chapel ..	—	Tues. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Denby Dale Victoria Memorial Hall .. (Phone Skelmanthorpe 3157)	Wed. p.m. (1st with IW) GP/HV/M with Infant Welfare Thurs. p.m. M *Relax.*	Wed. p.m. (1st & 3rd) GP/HV	Tues. p.m. Fri. p.m. HV	—	—	—	—	—	—	—	—	—	—	—	—
Emley Reading Rooms	—	Thurs. p.m. (3rd in month) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Golcar Woodville, Scar Lane .. (Phone: Milnsbridge 933)	Mon. p.m. (4th in month) ACMO/HV With Infant Welfare	Mon. p.m. ACMO/HV Toddlers quarterly by arrangement ACMO/HV	Tucs. p.m. Fri. p.m. HV	—	—	Wed. a.m. ST	—	—	—	—	As required HMO/HV	—	—	—	—
Greenfield Wesleyan Sunday School	—	Thurs. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Holmfirth Wesley Methodist Chapel	Thurs. p.m. (4th in month) ACMO/HV/M With Infant Welfare Thurs. a.m. M *Relax.*	Thurs. p.m. ACMO/HV	Mon. p.m. Thurs. a.m. HV	Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Honley Council Offices	—	—	—	—	—	Thurs. p.m. ST	—	—	—	—	—	—	—	—	—
Honley Dental Clinic Council Offices	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—

CLINICS—(*continued*)

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Honley High Street Methodist Church	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Honley Southgate Methodist Schools	—	Fri. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Huddersfield Old Boys' Pavilion, Tandem, Waterloo ..	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Huddersfield Royal Infirmary ..	—	—	—	—	—	—	—	—	—	—	—	Fri. p.m. (alternate) HMO/HV	—	—	E.N.T. Mon. a.m. As required HMO/HV
Kirkburton Drill Hall .. .. (Phone: Kirkburton 319)	Wed. a.m. M *Relax.*	Tues. p.m. ACMO/HV	—	—	—	Wed. p.m. ST	—	—	—	Mon.a./p.m. Wed.a./p.m. Thur.a./p.m. MH	—	—	—	By appointment	—
Lepton Council Offices, Wakefield Road	Thurs. p.m. (3rd in month with IW) ACMO/HV/M Tues. a.m. M *Relax.*	Thurs. p.m. ACMO/HV Toddlers quarterly by arrangement ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Linthwaite Methodist Church, Stones Lane	—	Tues. p.m. ACMO/HV Toddlers quarterly by arrangement ACMO/HV	—	—	—	—	—	—	—	Mon.a./p.m. Tues.a./p.m. Fri.a./p.m. MH	—	—	—	—	—
Marsden Conservative Club ..	—	Thurs. p.m. GP/HV Toddlers quarterly by arrangement ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Marsden Mechanics' Institute ..	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Meltham Baptist School	Thurs. p.m. (1st in month) ACMO/HV/M Tues. a.m. M *Relax.*	Tues. p.m. GP/HV Toddlers quarterly by arrangement ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Meltham Oddfellows Hall ..	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Meltham Town Hall	—	—	—	—	—	Mon. p.m. (alternate) ST	—	—	—	—	—	—	—	—	—
New Mill Council Offices .. .. (Phone: Holmfirth 194)	Wed. p.m. with IW Thurs. p.m. M *Relax.*	Wed. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Scholes County School	—	—	—	—	—	Thurs. a.m. ST	—	—	—	—	—	—	—	—	—
Skelmanthorpe Wesley Reform Chapel, Gib Lane	Wed. p.m. (4th in month) GP/HV With Infant	Wed. p.m. (2nd & 4th) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—

Slaithwaite Central Hall .. .. (Phone: Slaithwaite 419)	Wed. p.m. (1st in month) ACMO/HV With Infant Welfare Mon. p.m. HV/M *Relax.*	Wed. p.m. ACMO/HV Toddlers quarterly by arrangement ACMO/HV	—	—	—	Mon. p.m. (alternate) ST	—	—	—	—	—	—	—	—	—
Slaithwaite Municipal Offices ..	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Springhead Congregational Sunday School, Radcliffe Street ..	Mon. p.m. (2nd in month) ACMO/HV/M	Fri. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Uppermill Mechanics' Institute .. (Phone: Saddleworth 359)	Mon. p.m. (4th in month) ACMO/HV/M Thurs. p.m. M *Relax.*	Wed. p.m. ACMO/HV	Tues. a.m. Fri. a.m. HV	—	—	Mon. a.m. ST	—	—	—	—	As required HMO/HV	—	—	—	—
Uppermill The Park	—	—	—	—	—	—	—	—	—	—	—	—	—	By appoint- ment	—
DIV. 22 (WORTLEY)												See Div. 25			
Cawthorne The Golf Club	—	Wed. p.m. DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Chapeltown Miners' Welfare Institute	—	Wed. p.m. ACMO/HV	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Crow Edge Mobile Clinic No. 2 ..	With Infant Welfare	Thurs. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Dungworth Mobile Clinic No. 2 ..	With Infant Welfare	Fri. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Ecclesfield Gatty Memorial Hall ..	Thurs. p.m. GP/HV/M	Mon. p.m. GP/HV(2)	—	Mon. a.m. Thurs. a.m. HV	—	—	—	—	—	Mon. a.m. MH	—	—	—	—	—
Ecclesfield Jeffcock Memorial Home	—	—	Tues. p.m. Fri. p.m. HV	—	—	—	—	—	—	—	—	—	—	—	—
Ewden Valley Mobile Clinic No. 2 ..	With Infant Welfare	Fri. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Grenoside Scout Hut, Salt Box Lane	With Infant Welfare	Thurs. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
High Green Methodist Sunday School, Wortley Road	—	Tues. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Hoyland Miners' Welfare Institute	Mon. p.m. GP/HV/M Wed. p.m. M(2) *Relax.*	Tues. p.m. GP/HV(2)	—	Tues. a.m. Fri. a.m. HV	Tues. a.m. HV	—	—	—	—	Tues. a.m. MH	As required HMO/HV	—	—	—	—
Hoyland Common Methodist Sunday School	—	Thurs. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Loxley Congregation School ..	—	Tues. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Oughtibridge Church Hall	—	Thurs. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Parson Cross St. Paul's Institute ..	—	Tues. p.m. GP/HV(2)	—	—	—	—	—	—	—	Tues. a.m. Wed.a./p.m. MH	—	—	—	—	—

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Penistone Shrewsbury Road .. (Phone: Penistone 3205)	—	Mon. p.m. GP/HV(2)	—	Mon. a.m. HV	—	—	—	—	—	Thur.a./p.m. MH	As required HMO/HV	—	—	Daily	—
Stannington Methodist Sunday School	—	Wed. p.m. ACMO/HV	—	—	—	—	—	—	—	Mon.a./p.m. MH	—	—	—	—	—
Stocksbridge British Hall	—	Tues. p.m. GP/HV	—	—	—	—	—	—	—	Fri. a.m. MH	As required HMO/HV	—	—	—	—
Tankersley Scout Hall	—	Mon. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Thurgoland Mobile Clinic No. 2 ..	With Infant Welfare	Thurs. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Wharncliffe Side Brightholmlee Methodist Chapel	Tues. p.m. (alternate) HV/M *Relax.*	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Worrall Memorial Hall	Tues. p.m. (alternate) HV/M	Tues. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 23 (HEMSWORTH)															
Ackworth Mission Rooms, Wakefield Road	Tues. p.m. (alternate) GP/HV/M Tues. p.m. (alternate) M *Relax.*	Tues. p.m. (alternate) GP/HV Wed. p.m. (alternate) GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Fitzwilliam Church Hut	Thurs. p.m. GP/M(2)	Tues. p.m. ACMO/HV(2)	—	Tues. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Great Houghton Methodist Church ..	—	Tues. p.m. (alternate) GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Grimethorpe Church Hall	—	Wed. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Hemsworth New Clinic	Wed. a.m. ACMO/HV/ M(2)	Wed. p.m. ACMO/HV(2)	Tues. a.m. Fri. p.m. HV	—	Tues. a.m. ACMO/HV	Thur.a./p.m. Fri. a./p.m. ST.	—	—	Fri. a.m. ON	—	Tues. p.m. HMO/HV Thur.a./p.m. (4th in mth.) HMO/HV	Tues. p.m. (3rd in mth.) HMO/HV	—	Daily	—
Moorthorpe Miners' Institute	—	—	—	Fri. a.m. HV(2)	—	—	—	—	—	—	—	—	—	—	—
Ryhill Church Hall	Tues. p.m. GP/HV/M(2)	Thurs. p.m. (alternate) ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Shafton Methodist Chapel ..	—	Thurs. p.m. (alternate) GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
South Elmsall P.I.C.S. Buildings, Barnsley Road	Thurs. a./p.m. ACMO/HV/ M Tues. p.m. M *Relax.*	Mon. a./p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
South Hiendley Methodist Chapel ..	—	Wed. p.m. (alternate) ACMO/HV (2)	—	—	—	—	—	—	—	—	—	—	—	—	—

South Kirkby P.I.C.S. Buildings, The Green	Tues. p.m. ACMO/HV/M(2) Thurs. p.m. M(2) *Relax.*	Mon. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Upton Church Hall	—	Tues. p.m. (alternate) ACMO/HV(2)	—	Mon. p.m. HV	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 25 (BARNSLEY)																
Barnsley Divisional Office, 6 Victoria Road .. (Phone: Barnsley 2247)	—	—	—	—	—	—	—	—	—	—	Mon. a.m. (except 1st) Thurs. a.m. (except 3rd) HMO/HV	Fri. a.m. (last in month) HMO/HV Includes Div. 22	Mon. a.m. (1st in mth.) Thurs. a.m. (3rd in mth.) HMO/HV	—	—	
Barnsley Beckett Hospital	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Tues. a.m. (2nd in mth.) HMO/HV (2) See also Div. 30	
Cudworth St. George's Hall ..	Fri. a.m. GP/HV/M Thurs. a.m. M(2) *Relax.*	Wed. a./p.m. GP/HV(2)	Tues. p.m. Thurs. p.m. HV(2) Oct.—May	—	Tues. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—
Darfield Methodist Church, Barnsley Road	Fri. a.m. GP/HV/M Wed. a.m. M(2) *Relax.*	Wed. p.m. GP/HV	—	—	Wed. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—
Darton Station Road .. .. (Phone: Darton 437)	Wed. p.m. With I.W. GP/HV/M Tues. p.m. M *Relax.*	Wed. p.m. GP/HV	—	Wed. a.m. (1st in mth.) HV	Mon. p.m. (alternate) ACMO/HV	—	—	—	—	Fri. a./p.m. MH	—	—	—	—	—	—
Dodworth Mechanics' Institute ..	Tues. a.m. M *Relax.*	Tues. p.m. GP/HV	—	Tues. a.m. (alternate) HV	Tues. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—
Higham Parish Hall, Higham Common Road	Tues. p.m. DMO/HV/M with I.W.	Tues. p.m. DMO/HV	—	Tues. a.m. HV	Wed. a.m. (3rd in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—
Royston Wesleyan Sunday School, High Street	Tues. p.m. GP/HV/M	Wed. a./p.m. GP (1 session) /HV	—	Mon. a.m. HV	Fri. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—
Staineross Wesleyan Sunday School, Barnsley Road	Thurs. p.m. With Infant Welfare DMO/HV/M	Thurs. p.m. DMO/HV	—	Thurs. a.m. (except 2nd) HV	Thurs. a.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—
Wombwell Public Library, Station Road	Thurs. a./p.m. GP/HV(2)/M(2) Mon. a.m. Wed. p.m. M(3) *Relax.*	Tues. p.m. GP/HV(4)	Mon. p.m. Fri. p.m. HV	Fri. p.m. HV Mon. p.m. (alternate) HV	Mon. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—
Wombwell Welfare Hall, Jump ..	—	Mon. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Wombwell The Gables	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—	

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Ortho-paedic	Paedi-atric	Dental	Other
Worsbrough Methodist Church, Birdwell	Fri. p.m. (alternate) GP/HV/M Fri. p.m. M *Relax.*	Wed. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Worsbrough Methodist Chapel, Blacker Hill	—	Thurs. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Worsbrough Ambulance Hall, Worsbrough Bridge	Tues. p.m. (alternate) GP/HV/M Thurs. p.m. M *Relax.*	Mon. p.m. GP/HV	—	Mon. a.m. (alternate) HV	Mon. a.m. (alternate) ACMO/HV	—	—	—	—	Thurs. a.m. MH	—	—	—	—	—
Worsbrough Bank End Community Centre, Worsbrough Dale	Tues. p.m. (alternate) GP/HV/M Wed. p.m. M *Relax.*	Thurs. p.m. GP/HV	Mon. p.m. Fri. p.m. HV	Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
DIV. 26 (WATH)						See Div. 30									E.N.T. See Div. 30
Kilnhurst Church Hall	—	Wed. p.m. GP/HV(2)	—	—	Thurs. a.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Parkgate Methodist Church, Broad Street	—	Thurs. p.m. ACMO/HV(2)	—	—	Tues. p.m. (monthly) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Rawmarsh Barbers Avenue (Phone: Rawmarsh 133)	Thurs. a.m. GP/HV(2)/M Thurs. p.m. M *Relax.*	Tues. p.m. GP/HV(3)	Tues. a.m. Fri. a.m. HV	—	Wed. a.m. ACMO/HV	—	—	Mon.a./p.m. Ps/PI/PSW	—	Wed. p.m. Fri. a./p.m. MH	Wed. a./p.m. (alternate) HMO/HV	Wed. p.m. (monthly) HMO/HV Includes Div. 31	Thurs. a.m. (1st in mth.) HMO/ ACMO/HV *Dev.* Wed. a.m. (monthly) HMO/HV Includes neighbour'g divisions	Daily	—
Swinton Rock House (Phone: Mexborough 2057)	Thurs. a./p.m. GP/HV/M(2) Fri. p.m. M(2) *Relax.*	Mon. p.m. GP/HV(2)	—	—	Mon. a.m. (alternate) ACMO/HV	—	—	—	—	Mon. a.m. Tues. a./p.m. MH	—	—	—	—	—
Wath-on-Dearne Dunford House (Phone: Wath-on-Dearne 2251)	Fri. a.m. GP/HV(2)/ M(2) Tues. p.m. Fri. p.m. M(2) *Relax.*	Mon. p.m. GP/HV(2)	Mon. a.m. Thurs. a.m. HV	—	Mon. a.m. (alternate) ACMO/HV	—	—	—	—	Wed. a.m. Thurs. a.m. Fri. a.m. MH	Wed. a./p.m. (alternate) HMO/HV	—	—	Daily	—
West Melton Wesleyan Chapel, Princess Street	—	Tues. p.m. GP/HV(2)	—	—	Tues. a.m. (alternate) DMO/HV	—	—	—	—	—	—	—	—	—	—
DIV. 27 (ADWICK le STREET)												See Div. 28			
Bentley The Pavilion, Askern Road (Phone: Doncaster 54430)	Fri. a./p.m. GP/HV(2)/ M(4) Tues. a.m. M(2) *Relax.*	Wed. a./p.m. HV(3)/M(2) and DMO a.m. and ACMO p.m.	Mon. p.m. Wed. a.m. Sat a.m. HV	Tues. a.m. HV	—	—	Wed. a.m. (monthly) DMO/ HV(2)	—	—	Tues. a./p.m. MH	—	—	Mon. a.m. (monthly) HMO/HV	—	—

Bentley Bentley Road Chapel ..	—	—	—	Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—	—
Bentley Couneil Offices	—	—	—	—	—	—	Fri. a.m. DMO	—	—	—	—	—	—	—	—	—
Carcroft Presbyterian Chapel, Owston Road	Mon. p.m. (alternate) ACMO/HV (2)/M(2)	Thurs. a./p.m. HV(2)/M ACMO one session only	—	Fri. a.m. HV	—	—	Thurs. a.m. (monthly) DMO/ HV(2)	—	—	—	—	—	—	—	—	—
Doncaster Royal Infirmary ..	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Wed. a.m. (4th in mth.) HMO/HV
Doncaster Wood Street	—	—	—	—	—	—	—	—	—	—	Thurs. a./ p.m. (alternate) HMO/HV	—	—	—	—	—
Woodlands Woodside Chapel ..	Tues. a./p.m. GP/HV(2)/ M(2)	Thurs. a./p.m. HV(2) and DMO one session only	—	Thurs. a.m. HV	—	—	Thurs. a.m. (monthly) DMO/ HV(2)	—	—	Mon.a./p.m. Wed. a./p.m. Fri. a./p.m. MH	—	—	—	—	—	—
DIV. 28 (DONCASTER)																—
Armthorpe Miners' Welfare Institute	Tues. a.m. Tues. p.m. (2nd & 4th) ACMO/HV (2)/M	Thurs. p.m. GP/HV(2)	—	Wed. a.m. HV	—	—	Mon. a.m. (monthly) ACMO/HV	—	—	—	—	—	—	—	—	—
Askern Baptist Chapel, Sutton Road	Thurs. p.m. Thurs. a.m. (2nd & 4th) GP/HV(2)/M	Mon. p.m. ACMO/HV(2)	—	Mon. a.m. HV Thurs. a.m. (1st, 3rd & 5th) HV	—	—	Mon. a.m. ACMO/HV	—	—	—	—	—	—	—	—	—
Auckley Mobile Clinic No. 2 ..	—	Thurs. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Barnburgh Mobile Clinic No. 2 ..	—	Wed. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Bawtry 25 Council Estate ..	Wed. p.m. (2nd in mth.) ACMO/M	Mon. a.m. ACMO/HV	—	—	—	—	Mon. a.m. ACMO/HV	—	—	—	—	—	—	—	—	—
Blaxton Mobile Clinic No. 2 ..	—	Thurs. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Braithwell Mobile Clinic No. 2 ..	—	Fri. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Branton Mobile Clinic No. 2 ..	—	Thurs. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Brodsworth St. Leonard's and St. Jude's Church, Barnsley Road, Scawsby	—	Tues. p.m. (alternate) HV weighing only	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Campsall Mobile Clinie No. 2 ..	—	Tues. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Doncaster Nether Hall Road Methodist Church	—	—	—	—	—	—	—	—	Mon. a.m. ON	—	—	—	—	—	—	—

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Doncaster Chest Clinic, Merton House, 20 Christ Church Road	—	—	—	—	—	—	—	—	—	—	—	Thurs. p.m. (4th in mth.) HMO/ON for Divs. 27, 28, 29 & 30	—	—	—
Doncaster Royal Infirmary	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Wed. a.m. (3rd in mth.) HMO/HV
Doncaster Wood Street	—	—	—	—	—	—	—	—	—	—	Thurs. a./p.m. (alternate) HMO/HV	—	—	—	—
Edlington St. John's Church Hall ..	Thurs. a./p.m. (1st, 3rd & 4th) ACMO/HV (2)/M	Mon. p.m. ACMO/HV(2)	—	Mon. a.m. Fri. a.m. HV	—	—	Fri. a.m. (monthly) ACMO/HV	—	—	—	—	—	—	—	—
Finningley Mobile Clinic No. 2 ..	—	Thurs. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
High Melton Mobile Clinic No. 2 ..	—	Wed. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Kirk Sandall Denton Green's Lane .. (Phone: Barnby Dun 252)	Tues. p.m. (1st & 3rd) ACMO/ HV(2)/M	Thurs. p.m. GP/HV/M	—	Tues. a.m. HV	—	—	Mon. a.m. (monthly) ACMO/HV	—	—	—	—	—	—	—	—
Norton Mobile Clinic No. 2 ..	—	Tues. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Rossington St. Luke's Church Hall ..	—	Tues. p.m. GP/HV(2)	—	Tues. a.m. HV	—	—	Fri. p.m. (monthly) ACMO/HV	—	—	—	—	—	—	—	—
Rossington Dental Clinic West End Lane	Wed. a.m. ACMO/ HV(2)/M	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Sprotborough Richmond Hill School Grounds .. .. .. (Phone: Doncaster 65037)	Fri. a./p.m. (alternate) ACMO/HV/ M	Wed. a.m. DMO/HV	Mon. p.m. Thurs. p.m. HV Oct.—May	Thurs. a.m. HV	—	—	Wed. p.m. (monthly) DMO/HV	—	—	—	—	—	Mon. a.m. (3rd in mth.) HMO/HV	—	—
Tickhill Mobile Clinic No. 2 ..	—	Fri. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Wadworth Mobile Clinic No. 2 ..	—	Fri. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Warmsworth Mobile Clinic No. 2 ..	—	Wed. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 29 (THORNE)															
Doncaster Wood Street	—	—	—	—	—	—	—	—	—	—	Fri. a.m. (except last in month HMO/HV	See Div. 28 —	—	—	—
Doncaster Royal Infirmary ..	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Wed. a.m. (2nd in mth.) HMO/HV

Dunscroft St. Edwin's Hall	Wed. p.m. GP/M(2)	Tues. p.m. ACMO/HV(2)		Thurs. a.m. HV											
Hatfield Victoria Hall	Mon. p.m. GP/HV(2)	Mon. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Moorends Wesleyan Chapel, Northgate	Tues. p.m. GP/HV(2)	Tues. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Stainforth Wesleyan Chapel.. ..	Fri. a.m. GP/M(2)	Wed. p.m. ACMO/HV(2)	—	Mon. a.m. Wed. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Thorne Temperance Institute ..	Fri. p.m. GP/M(2)	Wed. p.m. GP/HV(2)	Mon. p.m. Thurs. a.m. HV	Tues. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Thorne Divisional Office, Council Offices	—	—	—	—	—	—	—	—	—	—	—	—	Thurs. a.m. (2nd in mth.) HMO/HV	—	—
DIV. 30 (MEXBOROUGH)								See Div. 26				See Div. 28			
Bolton-on-Dearne Secondary Modern School	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Conisbrough Miners' Welfare Institute, Garden Lane .. .. (Phone: Conisbrough 2150)	Tues. p.m. Obst/HV/ M(3)	Mon. p.m. ACMO/HV(2)	—	Mon. a.m. except on SC days, HV Thurs. p.m. (1st & 3rd) ACMO/HV	Twice monthly on MA days, ACMO/HV	—	—	—	—	—	—	—	—	—	—
Denaby Main Church Road .. .. (Phone: Conisbrough 3121)	Wed. a.m. Obst/HV/ M(3)	Tues. p.m. ACMO/HV(2)	Mon. a.m. ACMO/HV (2) Thurs. p.m. HV(2)	Tues. a.m. Thurs. a.m. except on SC days, HV	Twice per month on MA days ACMO/HV	—	—	—	—	Tues. a.m. Fri. p.m. MH	Thurs. a.m. (4th in mth.) HMO/HV	—	—	Daily	—
Goldthorpe Welfare Hall, Washington Road .. .. .. (Phone: Goldthorpe 3282)	Thurs. p.m. Obst/HV/ M(3)	Mon. p.m. ACMO/HV(2) /M	—	Mon. a.m. HV	—	—	—	—	—	Mon. a.m. MH	—	—	—	—	—
Mexborough Adwick Road .. .. (Phone: Mexborough 3347)	Wed. p.m. Obst./HV/ M(3) Mon. p.m. M *Relax.*	Tues. p.m. DMO/HV(3) Thurs. p.m. GP/HV(3)	Tues. a.m. ACMO/HV (2) Fri. a.m. HV(2)	Tues. a.m. Thurs. a.m. except on SC days, HV	Twice per month on MA days, ACMO/HV	Mon.a./p.m. Fri. a./p.m. ST Includes Div. 26	—	—	—	Wed. a.m. Thurs. a.m. MH	Mon.a./p.m. HMO/HV	—	Thurs. (4th in mth.) HMO/ ACMO(2) /HV	—	—
Mexborough Montagu Hospital ..	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Wed. p.m. HMO/HV Includes Divs. 25 & 26
Thurnscoe Central Hall .. .. (Phone: Goldthorpe 3128)	Fri. p.m. Obst/HV/ M(3)	Mon. p.m. GP/HV(2)/M	—	Mon. a.m. Fri. a.m. except SC days, HV	Monthly on MA days, ACMO/HV	—	— Tues. p.m. GP/HV(2)	—	—	Fri. a.m. MH	—	—	—	—	—
DIV. 31 (ROTHERHAM)												See Div. 26			
Aughton 9 Main Street	—	—	—	—	—	—	—	—	—	—	—	—	—	Wed. a./p.m. Fri. a./p.m.	—
Bramley Miners' Welfare Institute Cross Street	Tues. p.m. (alternate) GP/HV/M	Wed. p.m. GP/HV	—	Wed. a.m. HV	Tues. a.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Brampton Bierlow Methodist Chapel, Chapel Avenue	Wed. p.m. (alternate) GP/HV/M	Thurs. p.m. GP/HV	—	Thurs. a.m. HV	Thurs. a.m. (quarterly) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Brinsworth Mobile Clinic No. 2 ..	—	Tues. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Catcliffe 3 Rotherham Road .. (Phone: Rotherham 3381)	Thurs. p.m. (1st in mth.) ACMO/HV/M	—	—	Tues. a.m. HV	Thurs. a.m. (3rd in mth.) ACMO/HV	—	—	—	—	Mon. a./p.m. MH	—	—	—	—	—
Catcliffe Church Mission Hall ..	—	Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Dalton Doncaster Road .. .. (Phone: Thrybergh 327)	Wed. p.m. ACMO/HV/M Thurs. p.m. (alternate) ACMO/HV/M	Tues. p.m. GP/HV	—	Tues. a.m. HV Fri. a.m. HV	Thurs. a.m. (2nd in mth.) ACMO/HV	Tues. p.m. ST	Fri. a.m. (1st in mth.) ACMO/HV	—	—	Fri. a./p.m. MH	—	—	—	—	—
Dinnington Methodist Chapel, Laughton Road	Thurs. p.m. GP/HV/M	Tues. p.m. GP/HV	—	Tues. a.m. HV	Thurs. a.m. (4th in mth.) ACMO/HV	Tues. a.m. ST	—	—	—	Wed. a.m. MH	Thurs. p.m. (3 weeks out of 4) HMO/HV	—	—	—	—
Firbeck Mobile Clinic No. 2 ..	—	Mon. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Harley Mobile Clinic No. 2 ..	—	Wed. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Harthill Mobile Clinic No. 2 ..	—	Mon. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Kiveton Park Methodist Chapel, Wales Road	—	Mon. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Maltby Braithwell Road	—	—	—	—	—	—	—	—	—	—	—	—	—	Mon.a./p.m. Tues.a./p.m. Thurs.a./p..m.	—
Maltby Walters Road .. .. (Phone: Maltby 128)	Wed. a./p.m. ACMO/HV/M	Mon. p.m. ACMO/HV	Tues. a.m. Fri. p.m. HV Oct.—Apl.	Tues. a.m. Fri. a.m. HV	Mon. a.m. (1st in mth.) ACMO/HV	Thu.a./p.m. ST	Mon. a.m. (3rd in mth.) ACMO/HV	—	—	Tues.a./p.m. Thurs. a./p.m. MH	Thurs. p.m. HMO/HV	—	Mon. a.m. (2nd inmth.) HMO/HV	—	—
Ravenfield Common Mobile Clinic No. 2 ..	—	Wed. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Ravenfield Old Village Mobile Clinic No. 2 ..	—	Wed. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Rotherham Hospital and Dispensary	—	—	—	—	—	—	—	—	—	—	Fri. a.m. HMO/HV	—	—	—	E.N.T. Wed. a./p.m. (1st in mth.) HMO/HV
South Anston Mobile Clinic No. 2 ..	—	Mon. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—

Church Hall, Beighton Lane	(alternate) GP/HV/ M	HV Thurs. p.m. GP/HV		a./p.m. except SC, HV	(2nd in mth.) ACMO/HV											
Thurcroft Wesleyan Chapel, Woodhouse Green ..	Wed. p.m. (1st & 3rd) GP/HV/M	Mon. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Thurcroft Modern School	—	—	—	Mon. a.m. Thurs. a.m. HV	Tues. a.m. (1st in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—
Thrybergh Poplar Avenue	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Treeton Mobile Clinic No. 2 ..	—	Tues. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Wentworth Mobile Clinic No. 2 ..	—	Wed. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Whiston Church Institute, School Hill	—	Thurs. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Woodsetts Mobile Clinic No. 2 ..	—	Mon. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—

In addition to the above there are 91 minor ailment clinics held by school nurses in the schools, chiefly at weekly intervals, and minor ailment cases are also treated at 85 centres during Infant Welfare Sessions. There are also three Dental Trailer Caravans operating in rural areas.

NOTE:—The following abbreviations are used.

DMO.	Divisional Medical Officer.	Ps.	Psychiatrist.	ST.	Speech Therapist.
ACMO.	Assistant County Medical Officer (Senior or other)	Pl.	Psychologist.	MH.	Mental Health Staff.
Obst.	Joint Obstetrician (W.R.C.C. and Sheffield R.H.B.).	PSW.	Psychiatric Social Worker.	Ch.	Chiropodist.
GP.	General Practitioner.	HV.	Health Visitor and/or School Nurse.	*Relax.*	Relaxation Exercise Clinic.
HMO.	Hospital Medical Officer (Consultant or Other).	M.	Midwife.	*Dev.*	Developmental.
		ON.	Orthopaedic Nurse or Physiotherapist.		

STAFF

(31st December, 1956)

J. Wood-Wilson, T.D., M.D., CH.B., D.P.H.

(County Medical Officer and Principal School Medical Officer)

HEADQUARTERS

MEDICAL, DENTAL AND PROFESSIONAL

J. Leiper, M.B.E., M.B., CH.B., M.R.C.S., L.R.C.P., D.P.H.	Deputy County Medical Officer
J. M. Anderson, M.R.C.S., L.R.C.P.	Senior Medical Officer
A. Marshall, M.B., CH.B.	Senior Medical Officer
J. A. Burgess, M.D., CH.B., D.P.H.	Venereologist (Part-time)
C. C. Harvey, B.SC., M.D., B.S., F.R.C.S., M.R.C.P.	Paediatrician (Part-time)
S. M. Leese, B.SC., M.B., B.S., M.R.C.S., L.R.C.P., D.P.M.	Psychiatrist in Child Guidance (Part-time)
J. D. Orme, M.R.C.S., L.R.C.P., D.P.M.	Psychiatrist in Child Guidance (Part-time)
B. R. Townend, F.D.S., R.C.S. (ENG.), DIP. ORTH., R.C.S. (ENG.), L.D.S.	Chief Dental Officer, Principal School Dental Officer and Orthodontic Consultant
D. G. Pickles, M.A.	Child Guidance Psychologist

NURSING

Miss D. Walker, S.R.N., S.C.M., H.V.CERT.	Superintendent Nursing Officer (*on leave of absence with World Health Organisation*)
Miss A. Carey, S.R.N., S.C.M., H.V.CERT., F.R.S.H.	Superintendent Health Visitor (*Acting Superintendent Nursing Officer*)
Miss R. O'Brien, S.R.N., S.C.M., H.V.CERT.	Superintendent Health Visitor
Miss E. B. Cribb, S.R.N., S.C.M., H.V.CERT.	Acting Superintendent Health Visitor
Miss M. G. Edwards, S.R.N., S.C.M. (PART I), H.V.CERT., H.V.TUTOR'S CERT.	Health Visitor Tutor
Miss E. M. Taylor, S.R.N., S.C.M., M.T.D.	Supervisor of Midwives
Miss N. M. Everitt, S.R.N., S.C.M., M.T.D.	do.
Miss G. Jones, S.R.N., S.C.M., H.V.CERT., Q.I.D.N.S.	Supervisor of Home Nurses
Mrs. W. Taylor, S.R.N., S.C.M., H.V.CERT., Q.I.D.N.S.	do.
Vacancy	Chief Speech Therapist

TECHNICAL

L. Butterworth [1], [2], [4], [5], [10]	Chief County Public Health Inspector
R. D. Irving [1], [2], [6], [8], [9]	County Public Health Inspector
F. C. Brookes [1], [2]	do.

ADMINISTRATIVE AND CLERICAL

J. Colman [1], [3], [7]	Chief Clerk
G. Richardson [6]	Sectional Clerk
H. Bywater	do.
J. H. Milne [6]	do.
R. S. Marshall	do.
H. Beatson	do.
T. R. Schofield [6]	do.
W. J. Battye	Senior Clerk
A. R. Micklethwaite	do.

[1] Sanitary Inspectors' Cert. Royal Sanitary Inst.
[2] Cert. as Inspector of Meat and Other Foods, Royal Sanitary Inst.
[3] Exam. in Sanitary Science as applied to Buildings and Public Works, Royal San. Inst.
[4] Final Cert. Builders' Quantities, London City and Guilds.
[5] Final Cert. (Distinction) Builders' Quantities, Lancashire and Cheshire Inst.
[6] Diploma in Public Administration.
[7] Associate Chartered Institute of Secretaries.
[8] Sanitary Science Cert. (Liverpool University).
[9] Cert. in Advanced Knowledge of Sanitary Inspectors' duties, Royal Sanitary Inst.
[10] Building Trades Course Certificate, Lancashire and Cheshire Inst.

DIVISIONAL MEDICAL OFFICERS

M. Hunter, M.B.E., M.D., CH.B., D.P.H.	Division No. 1 (Skipton)
Vacancy	,, No. 2 (Settle)
H. M. Holt, T.D., M.B., B.S.(LOND.), M.B., CH.B.(LEEDS), D.P.H.	,, No. 3 (Keighley)
J. Battersby, M.B., CH.B., D.P.H.	,, No. 4 (Shipley)
Vacancy	,, No. 5 (Horsforth)
Vacancy	,, No. 6 (Otley)
N. V. Hepple, M.D., B.S., B.HY., D.P.H.	,, No. 7 (Ripon)
D. D. Payne, M.D., B.S., M.R.C.S., L.R.C.P., D.P.H.	,, No. 8 (Harrogate)
R. G. Smithson, M.D., CH.B., D.P.H.	,, No. 9 (Wetherby)
S. K. Appleton, M.D., CH.B., D.P.H., D.T.M.	,, No. 10 (Goole)

DIVISIONAL MEDICAL OFFICERS—continued

J. M. Paterson, M.B., CH.B., D.P.H.	Division No. 11 (Castleford)
J. F. Fraser, M.B., B.S., D.P.H., D.OBST.R.C.O.G.	,, No. 12 (Pontefract)
F. G. E. Hill, D.S.O., M.B., CH.B., D.P.H.	,, No. 13 (Morley)
J. F. Caithness, M.B., CH.B., D.P.H.	,, No. 15 (Batley)
A. L. Taylor, M.D., CH.B., D.P.H., L.D.S.	,, No. 16 (Rothwell)
W. M. Douglas, M.B., CH.B., D.P.H.	,, No. 17 (Spenborough)
F. Appleton, M.B., CH.B., D.P.H.	,, No. 18 (Brighouse)
J. Lyons, M.B., CH.B., M.R.C.S., L.R.C.P., D.P.H.	,, No. 19 (Todmorden)
E. Ward, M.R.C.S., L.R.C.P., D.P.H.	,, No. 20 (Colne Valley)
J. Main Russell, M.B., CH.B., B.HY., D.P.H.	,, No. 22 (Wortley)
J. S. Walters, M.C., M.B., CH.B., D.P.H.	,, No. 23 (Hemsworth)
R. Barnes, B.A., M.R.C.S., L.R.C.P., D.P.H.	,, No. 25 (Barnsley)
D. J. Cusiter, M.B., CH.B., D.P.H., D.T.M. & H.	,, No. 26 (Wath upon Dearne)
J. Ferguson, M.B., CH.B., D.P.H.	,, No. 27 (Adwick le Street)
A. Penman, M.D., CH.B., D.P.H.	,, No. 28 (Doncaster)
G. Higgins, B.SC., M.B., CH.B., D.P.H.	,, No. 29 (Thorne)
J. A. W. Reid, M.B., CH.B., D.P.H.	,, No. 30 (Mexborough)
J. M. Watt, M.D., CH.B., D.P.H., D.C.H., D.OBST.R.C.O.G.	,, No. 31 (Rotherham)

ASSISTANT COUNTY MEDICAL OFFICERS AND SCHOOL MEDICAL OFFICERS

C. Harris, B.A., M.B., B.CH.	Division No. 1 (Skipton)
R. R. Stoakley, M.B., B.CH., B.A.O.	,, No. 1 (Skipton)
N. M. E. Robertshaw, B.SC., M.B., CH.B., D.C.H., D.OBST.R.C.O.G.	,, No. 2 (Settle)
*B. M. Leakey, M.B., B.S.	,, No. 3 (Keighley)
D. E. Gledhill, M.B., CH.B.	,, No. 3 (Keighley)
*G. Buckle, M.B., B.S.	,, No. 4 (Shipley)
D. C. Wall, B.A., M.R.C.S., L.R.C.P.	,, No. 4 (Shipley)
*H. M. Mitchell, M.B., CH.B.	,, No. 5 (Horsforth)
M. A. Hillis, M.B., CH.B.	,, No. 6 (Otley)
P. A. G. M. Ashmore, M.R.C.S., L.R.C.P.	,, No. 7 (Ripon)
*J. A. G. Graham, M.B., CH.B., D.P.H.	,, No. 8 (Harrogate)
G. M. Pullan, B.SC., M.B., CH.B., D.OBST.R.C.O.G.	,, No. 8 (Harrogate)
W. Turner, M.B., CH.B., D.P.H.	,, No. 8 (Harrogate)
M. K. Sharp, M.R.C.S., L.R.C.P.	,, No. 9 (Wetherby)
E. M. R. Bell-Syer, M.B., B.S.	,, No. 10 (Goole)
M. J. Lowe, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H., D.C.H.	,, No. 10 (Goole)
*M. C. Leen, M.B., B.CH., B.A.O., D.P.H.	,, No. 11 (Castleford)
J. E. Fahy, L.R.C.P., L.R.C.S.	,, No. 11 (Castleford)
G. M. Mayhall, M.R.C.S., L.R.C.P.	,, No. 12 (Pontefract)
J. C. White, M.B., B.S., M.R.C.S., L.R.C.P., D.C.H.	,, No. 12 (Pontefract)
*B. Briggs, M.B., CH.B., D.P.H.	,, No. 13 (Morley)
I. Hargreaves, M.B., CH.B.	,, No. 13 (Morley)
M. H. Witt, L.R.C.P., L.R.C.S., D.P.H.	,, No. 13 (Morley)
G. Castle, M.R.C.S., L.R.C.P.	,, No. 15 (Batley)
F. M. Cox, M.R.C.S., L.R.C.P.	,, No. 15 (Batley)
R. M. Bowker, B.A., M.B., CH.B., D.P.H.	,, No. 16 (Rothwell)
D. M. Summers, M.B., CH.B.	,, No. 16 (Rothwell)
G. Cust, M.B., CH.B., D.P.H.	,, No. 17 (Spenborough)
C. A. Price, M.B., CH.B.	,, No. 17 (Spenborough)
*R. D. Haigh, M.B., CH.B., D.P.H., D.OBST.R.C.O.G.	,, No. 18 (Brighouse)
E. Atkinson, M.B., CH.B., D.OBST.R.C.O.G.	,, No. 18 (Brighouse)
*N. E. Gordon, M.B., CH.B., D.P.H.	,, No. 19 (Todmorden)
G. V. Bradshaw, M.B., B.S., D.OBST.R.C.O.G.	,, No. 19 (Todmorden)
*K. M. C. Haigh, M.B., CH.B., C.P.H., D.OBST.R.C.O.G.	,, No. 20 (Colne Valley)
*W. P. B. Stonehouse, M.A., M.R.C.S., L.R.C.P., D.P.H.	,, No. 20 (Colne Valley)
B. R. Ellis, M.R.C.S., L.R.C.P.	,, No. 20 (Colne Valley)
E. D. Shaw, M.B., B.CH., B.A.O.	,, No. 20 (Colne Valley)
*J. J. Smith, M.B., CH.B., D.P.H.	,, No. 22 (Wortley)
S. Lindsay, M.B., CH.B.	,, No. 22 (Wortley)
*E. E. Cromb, M.B., CH.B., D.P.H.	,, No. 23 (Hemsworth)
J. Hayes, M.B., CH.B.	,, No. 23 (Hemsworth)
S. G. A. Henriques, M.B., CH.B.	,, No. 25 (Barnsley)
M. R. Menzies, M.B., CH.B., D.C.H.	,, No. 26 (Wath upon Dearne)
A. Kropacz, L.R.C.P., L.R.C.S.	,, No. 27 (Adwick le Street)
M. T. Burton, B.A., L.M.S.S.A., L.M.	,, No. 28 (Doncaster)
C. M. Dornan, M.B., B.CH., B.A.O.	,, No. 28 (Doncaster)
R. B. Laidlaw-Becker, M.D., CH.B., M.R.C.S., L.R.C.P., D.P.H., D.P.M.	,, No. 29 (Thorne)
*B. R. A. Demaine, M.B., CH.B., D.P.H.	,, No. 30 (Mexborough)
H. F. Lindsay, M.B., CH.B.	,, No. 30 (Mexborough)

ASSISTANT COUNTY MEDICAL OFFICERS AND SCHOOL MEDICAL OFFICERS—Continued

*A. P. Gorrie, M.B., CH.B.	Division No. 31 (Rotherham)
M. J. Hallinan, M.R.C.S., L.R.C.P.	„ No. 31 (Rotherham)
J. Lodwick, B.A., M.B., B.CH.	„ No. 31 (Rotherham)

111 General Medical Practitioners who act as Child Welfare Centre Medical Officers and are employed on a sessional basis. This is the equivalent of 13·6 whole-time Assistant County Medical Officers.

*Senior Assistant County Medical Officer and School Medical Officer.

OBSTETRICIAN (Joint Appointment with Hospital Services)

J. C. MacWilliam, L.R.C.P., L.R.C.S., L.R.F.P. & S., D.OBST.R.C.O.G.

CHEST PHYSICIANS (Joint Appointments with Hospital Services)

SHEFFIELD REGION

D. H. Anderson, V.R.D., M.D., B.CH., B.A.O., D.P.H.
H. A. Crowther, M.A., M.R.C.S., L.R.C.P.
F. C. N. Holden, M.D., B.S., M.R.C.S., L.R.C.P.
A. C. Morrison, M.D., CH.B., D.P.H.

LEEDS REGION

R. G. Benians, M.A., M.D., B.CHIR., M.R.C.P.
D. J. Charley, M.D., B.S., M.R.C.P., M.R.C.S.
J. A. Dick, M.B., CH.B.
R. S. Donaldson, M.D., CH.B., D.T.M., D.P.H.
P. A. Duke, M.D., CH.B., D.P.H.
G. F. Edwards, M.B.E., M.B., B.S., M.R.C.S., M.R.C.P.
H. Grunwald, M.D. (VIENNA).
W. D. Hamilton, M.B., B.CH., B.A.O., D.P.H.
G. Henry, M.B., B.CH., B.A.O.
D. A. Herd, L.R.C.P., L.R.C.S., L.R.F.P. & S.
J. W. Jordan, M.D., B.S., M.R.C.S., M.R.C.P.
B. T. Mann, B.SC., M.D., CH.B., D.P.H.
M. S. Oxley, M.B., CH.B., T.D.D.
H. E. Raeburn, M.D., B.S., L.M.S.S.A., D.P.H.
A. D. Rankin, M.B., CH.B., D.P.H.
V. Ryan, M.D., B.CH., B.A.O., D.P.H.
J. K. Scott, M.B., CH.B., M.R.C.P., D.P.H.
D. K. Stevenson, M.B., CH.B., M.R.C.P.
J. Viner, M.B., CH.B.
J. Y. Walker, M.B., CH.B., D.P.H.
R. N. Walker, M.D., CH.B., D.P.H.
A. Weleminsky, M.D. (PRAGUE).
S. P. Wilson, M.SC., M.D., CH.B., D.P.H.

OTHER SPECIALIST STAFF

There are 56 Ophthalmic, 15 Ear, Nose and Throat, 17 Orthopaedic, 17 Paediatric, 1 Dermatological and 1 Cardiac clinics, the service of consultants or Senior Hospital Medical Staff being supplied by either the Regional Hospital Boards or Leeds University.

ORTHODONTIC SPECIALIST

R. Sclare, DIP. ORTH., R.C.S. (ENG.), L.D.S.

SENIOR DENTAL OFFICERS

J. M. Enderby, L.D.S.
O. A. Long, L.D.S.
E. Millward, L.D.S.

SCHOOL DENTAL OFFICERS

I. F. Ash, B.CH.D.
W. J. Brown, L.D.S.
G. H. Bulcock, L.D.S.
F. W. Buzza, L.D.S.
B. C. Clay, L.D.S.
K. R. Cowell, L.D.S.
J. M. Davison, L.D.S.
W. H. Dyke, L.D.S.
J. K. Ellwood, B.CH.D.
C. H. Elphick, L.D.S.
P. F. A. Eltome, L.D.S.
J. D. Franks, L.D.S.
M. M. Gibson, L.D.S.
M. Hattan, L.D.S.
S. Henry, L.D.S.
A. M. Holburn, L.D.S.
F. Kershaw, L.D.S.
S. Levinson, L.D.S.
F. Lister
E. S. Midgley, L.D.S.
S. Mitchinson, L.D.S.
D. B. Owen, L.D.S.
M. H. Platford, L.D.S.
D. G. Rennie, L.D.S.
J. Rothera, L.D.S.
F. H. Sanderson, L.D.S.
S. S. Sanderson, L.D.S.
S. E. Schloss, L.D.S.
B. Sleight, B.CH.D.
H. Taylor, L.D.S.
M. M. Thom, L.D.S.
G. A. Thompson, B.CH.D.
E. Thornton, L.D.S.
P. W. Thornton, L.D.S.
J. Todd, L.D.S.
B. Watts
H. M. Yuile, L.D.S.

11 Part-time.

DENTAL LABORATORY

J. O. Ford, Senior Dental Technician.
9 Technicians.
2 Boy Dental Apprentices.

HEALTH VISITORS, MIDWIVES, MEDICAL AUXILIARIES, Etc.

6 Divisional Superintendent Health Visitors.
295 Health Visitors and School Nurses.
7 Orthopaedic Nurses and Physiotherapists (3 part-time).
2 Psychiatric Social Workers (1 part-time).
11 Tuberculosis Visitors.
293 Home Nurses and Home Nurse Midwives.
192 Midwives.
1,759 Domestic Helps (17 whole-time and 1,742 part-time).
4 Venereal Diseases Social Workers (Qualified Health Visitors).
9 Speech Therapists (1 part-time).
1 Chiropodist (part-time).
1 Supervisor of Mental Health Occupation Centres and Teachers of the Mentally Handicapped (Vacancy).
16 Mental Health Social Workers.
22 Teachers of the Mentally Handicapped (2 part-time).
49 Dental Attendants.

COUNTY ANALYST (Part-time)

R. Mallinder, B.SC., F.R.I.C.
J. C. Harrel, F.R.I.C. (Deputy).

DAY NURSERIES

6 Day Nurseries—total nursing staff 39.

MENTAL HEALTH OCCUPATION CENTRES

Castleford—1 Supervisor; 2 Assistant Supervisors; 1 Nursery Assistant.
Keighley—1 Supervisor; 1 Assistant Supervisor; 3 Nursery Assistants (1 part-time).
Hemsworth—1 Supervisor; 3 Nursery Assistants.

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